SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: 2011 AR Admin Guide	SERFF Tr Num: UHLC-126996988	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Filed-Closed	State Tr Num: 47765
Sub-TOI: H21.000 Health - Other	Co Tr Num:	State Status: Filed-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Ebony Terry	Disposition Date: 01/21/2011
	Date Submitted: 01/21/2011	Disposition Status: Filed-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type:	Overall Rate Impact:
Filing Status Changed: 01/21/2011	
State Status Changed: 01/21/2011	Deemer Date:
Created By: Ebony Terry	Submitted By: Ebony Terry
Corresponding Filing Tracking Number:	
PPACA: Not PPACA-Related	
PPACA Notes: null	

Filing Description:

2011 AR Admin Guide

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst	Ebony_N_Terry@uhc.com
800 King Farm Blvd.	240-632-8053 [Phone]
Suite 500	

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Rockville, MD 20850

Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300	Group Name:	State ID Number:
Little Rock, AK 72205	FEIN Number: 63-1036819	
(952) 992-7428 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 Form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	$50.00	01/21/2011	43978216

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Rosalind Minor	01/21/2011	01/21/2011

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/21/2011
Implementation Date:
Status: Filed-Closed
HHS Status: Not Reported
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Filed-Closed	No
Supporting Document	Application	Filed-Closed	No
Supporting Document	Health - Actuarial Justification	Filed-Closed	No
Supporting Document	Outline of Coverage	Filed-Closed	No
Supporting Document	PPACA Uniform Compliance Summary	Filed-Closed	No
Supporting Document	Cover Letter	Filed-Closed	No
Form	2011 AR Admin Guide	Filed-Closed	No

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 100-6088 12/10

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed-Closed 01/21/2011	100-6088 12/10	Outline of Coverage	2011 AR Admin Guide	Initial			100-6088 UHC admin guide 2011 bookmarked (2).pdf

Physician, Health Care Professional, Facility and Ancillary Provider 2011 Administrative Guide

For Commercial and Medicare Products

UnitedHealthcare®

Table of contents

Important information regarding the use of this Guide

This Guide applies to all covered services which you provide to Customers under a benefit plan insured by or receiving administrative services from UnitedHealthcare and its affiliates, unless otherwise noted. In the event your agreement indicates that additional protocols or guides are applicable to Customers covered under certain benefit plans, those other protocols and guides will control with respect to such Customers.

Unless otherwise specified herein, this Guide is effective on April 1, 2011 for physicians, health care professionals, facilities and ancillary providers currently participating in the UnitedHealthcare network and effective immediately for physicians, health care professionals, facilities and ancillary providers who join the UnitedHealthcare network on or after January 1, 2011.

In the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your agreement and this Guide, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope of that Regulatory Requirements Appendix. Additionally, in the event of a conflict or inconsistency between your agreement and this Guide, the provisions of your agreement with us will control. This entire Guide is subject to change.

All items within this Guide that describe how you must do business with us are Protocols under the terms of your agreement.

This Guide refers to a "Customer" as a person eligible and enrolled to receive coverage from a payer for covered services as defined in your agreement with us. "Commercial" as used in this Guide refers to all UnitedHealthcare medical products that are not Medicare, Medicaid, TRICARE, worker's compensation or other governmental products. "Guide" refers to this 2011 Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. "You" or "your" refers to any provider subject to this Guide, including physicians, health care professionals, facilities and ancillary providers; unless otherwise specified in the specific item, all items are applicable to all types of providers subject to this Guide. "Us," "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Guide.

Except when indicated, this entire Guide applies to UnitedHealthcare Medicare Advantage Customers, including Erickson Advantage Customers. If a particular section does not apply to Medicare Advantage or Erickson Advantage Customers, it will be clearly indicated in this Guide. As used in this Guide, references to "Medicare Customers" only apply to those Medicare Customers enrolled in UnitedHealthcare Medicare benefit plans offered through the AARP® MedicareComplete, SecureHorizons, Evercare, UnitedHealthcare and Erickson Advantage brands.

UnitedHealthcare is not affiliated with other external websites listed in this guide.

Note: The codes and code ranges listed in this Guide were current at the time this Guide was published. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide for appropriate codes or visit UnitedHealthcareOnline.com for further information.

Information regarding other UnitedHealthcare entities

Some of the Benefit Plans that may be included under your agreement with us are subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). Below is a table setting forth a general guide to where those Additional Manuals are located.

Please note that UnitedHealthcare may change the location of a website, Benefit Plan name, branding or the Customer identification card identifier used to identify Customers subject to a given Additional Manual. If and when these changes occur, we will communicate with you about them.

Benefit plan	States membership is principally located (location subject to your agreement)	Applicable Provider Guide and website	Are Medicare Advantage plans included? If so, does the additional manual apply to those Medicare Advantage benefit plans?
Benefit Plans issued or administered by any of the following entities: • Oxford Health Plans, LLC; • Oxford Health Insurance, Inc. • Investors Guaranty Life Insurance Company, Inc. • Oxford Health Plans (NY), Inc. • Oxford Health Plans (NJ), Inc. • Oxford Health Plans (CT), Inc.	CT, NJ, NY (except upstate), some counties in PA.	Oxford Provider Reference Manual oxhp.com	Yes. Benefit details included in the Oxford Provider Reference Manual.
Benefit Plans issued or administered by any of the following entities: • MD-Individual Practice Association, Inc. ("MDIPA") • Optimum Choice, Inc. ("OCI") • MAMSI Life & Health Insurance Company ("MLH")	DC, DE, MD, NC, SC, VA, WV, some counties in PA	Mid-Atlantic Regional Supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide UnitedHealthcareOnline.com	No
Benefit Plans accessing a network administered by OneNet PPO, LLC ("OneNet")	DC, DE, MD, NC, SC, VA, WV, some counties in PA.	OneNet PPO Supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide UnitedHealthcareOnline.com	No
Benefit Plans issued or administered by Neighborhood Health Partnership, Inc. ("NHP")	FL	Neighborhood Health Partnership Supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide UnitedHealthcareOnline.com	No

Benefit plan	States membership is principally located (location subject to your agreement)	Applicable Provider Guide and website	Are Medicare Advantage plans included? If so, does the additional manual apply to those Medicare Advantage benefit plans?
Benefit Plans issued or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC, including any of the following entities: • PacifiCare Life and Health Insurance Company • PacifiCare Life Assurance Company • PacifiCare of Arizona, Inc. • PacifiCare of California • PacifiCare of Colorado, Inc. • PacifiCare of Nevada, Inc. • PacifiCare of Oklahoma, Inc. • PacifiCare of Oregon, Inc. • PacifiCare of Texas, Inc. • PacifiCare of Washington, Inc. Note: Please be aware that there may be changes in 2011 to the PacifiCare name and the branding associated with the family of PacifiCare companies listed above. If and when these changes occur, we will communicate with you about them	AZ, CA, CO, NV, OK, OR, TX, WA	PacifiCare Supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide Yes. Benefit details included in the PHS Supplement UnitedHealthcareOnline.com	Yes. Benefit details included in the PacifiCare Supplement
Benefit Plans issued or administered by • UnitedHealthcare Services Company of the River Valley, Inc. • UnitedHealthcare Plan of the River Valley, Inc. • UnitedHealthcare Insurance Company of the River Valley Note: This additional manual only applies where the back of a valid identification card of any Customer eligible for and enrolled in a Benefit Plan contains a reference to "uhcrivervalley.com."	AR, GA IA, IL, MO, TN, WI, VA. (SC expected during 2011). Note: River Valley Entities also offer Benefit Plans in OH, but the River Valley Provider Manual does not apply to those Benefit Plans.	River Valley Provider Manual uhcrivervalley.com	Yes, but the River Valley Provider Manual does not apply to Medicare Advantage Benefit Plans.
Benefit Plans issued or administered by one of the following entities and accessing the UnitedHealthcare network outside of Nevada, as indicated by a reference to "UnitedHealthcare ChoicePlus Network Outside Nevada" on the back of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan: • Sierra Health and Life Insurance Co., Inc. • Health Plan of Nevada, Inc.	NV	Benefit Plans for Sierra Health and Life Insurance Co., Inc.: sierrahealthandlife.com Benefit Plans for Health Plan of Nevada, Inc.: healthplanofnevada.com	Yes. Benefit details included in the Sierra Health Plans Provider Manuals.
Evercare Medicaid Benefit Plans (as indicated by a reference to "Evercare" on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan).	AZ, FL, HI, ID, MN, NM, TX	Evercare Medicaid Provider Manual evercarehealthplans.com	No

Benefit plan	States membership is principally located (location subject to your agreement)	Applicable Provider Guide and website	Are Medicare Advantage plans included? If so, does the additional manual apply to those Medicare Advantage benefit plans?
Medicare, Medicaid and other state governmental health program Benefit Plans as indicated by a reference to the following on the face of the valid identification card of any Customer eligible for and enrolled in that Benefit Plan: • UnitedHealthcare Community Plan • Dual Complete • AmeriChoice • Unison • Personal Care Plus • Secure Plus Complete • Texas STAR • Texas Children's Health Insurance Program Note: Please be aware that there may be changes in 2011 to the Benefit Plan name and the branding associated with the family of AmeriChoice and Unison companies listed above. If and when these changes occur, we will communicate with you about them.	AZ, CT, DC, DE, FL, IA, MD, MI, MS, NE, NV, NJ, NY, OH, PA, RI, SC, TN, TX, WI.	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Manual. All such guides are contained in the website under the applicable state. uhccommunityplan.com	Yes. Benefit details included in the additional manuals for each applicable state

Network bulletin

UnitedHealthcare publishes 6 editions annually of a user-friendly online notice of updates to our policies, protocols, programs and other interesting items that help our network physicians and facilities know about these changes. The Network Bulletin is posted online at UnitedHealthcareOnline.com → Most Visited → Network Bulletin. Here, you also can sign up to receive the Network Bulletin via email. The email distribution is not limited to only one person in your office - have everyone sign up! Postcard announcements will be mailed where required by law.

The Network Bulletin will be available at UnitedHealthcareOnline.com on the following dates in 2011:

January 3	March 1	May 2	July 5	September 6	November 1

Read the Network Bulletin throughout the year to view information on important topics as well as pharmaceutical benefit management information.

Important news and updates

Our preferred method to communicate with you is electronically, and any news or updates regarding policy, product, or reimbursement changes are generally posted in the news section of UnitedHealthcareOnline.com and/or in the Network Bulletin. Where required by law, updates will be provided in writing. We also use multiple channels (mail, internet, email, telephone and facsimile) to communicate with you in the event a Protocol is modified. We will notify you prior to implementation of a Protocol change if specified in your agreement with us or if required by law. To the extent that some Protocols are applicable only in certain states at the time of printing, we have indicated that in this Guide. Please reference UnitedHealthcareOnline.com to view a complete list of states to which Protocols are applicable. To register to use UnitedHealthcareOnline.com, simply select the 'New User' link in the upper right corner of the UnitedHealthcareOnline.com home page, and follow the prompts.

How to contact us

Commercial & Medicare Products		
Resource	**Where to go**	**What you can do there**
UnitedHealthcare Online®	UnitedHealthcareOnline.com	• Register for UnitedHealthcare Online • Review a Customer's eligibility or benefits and their current HRA balances • Submit notifications • View claim pre-determination and bundling logic using claim Estimator (for Commercial Customers only) • Submit claims with Real-Time Adjudication (for Commercial Customers only) • Check status of or update existing notifications • Check claims status • Request a claims adjustment or a reconsideration when attachments are not needed • Submit a claim research project for 20 or more claims using the claim Research Project online form • Update facility/practice data (except tax identification number (TIN)) • Review the physician, health care professional, and facility directory • Look up your fee schedule, 10 codes at a time • Review/print a current copy of this Guide • View UnitedHealthcare policies • View current and past issues of our Network Bulletin • Access and review clinical program information and patient safety resources • View the Credentialing and Recredentialing Plan
	(866) UHC-FAST (842-3278), Option 2	• Get technical support for UnitedHealthcare Online
Electronic Claim Submission (EDI Support Line)	(800) 842-1109 To obtain information on HIPAA Transactions & code sets go to hipaa.uhc.com → Uniprise → Companion Document Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com → Claims & Payments → Electronic Claims Submissions, under EDI Tools & Resources	• Obtain information on submitting claims electronically • Use our payer ID 87726
Enhanced Voice Portal	(877) UHC-3210 (842-3210) To obtain a Enhanced Voice Portal Quick Reference Process Overview, go to UnitedHealthcareOnline.com → Contact Us, then reference the Service & Support Section. click on the quick reference link under UnitedHealthcare for Health care Professionals (Enhanced Voice Portal)	• Inquire about a Customer's eligibility or benefits (including copayments, deductibles, past/current coverage, coinsurance, and out-of-pocket information) and obtain a faxed confirmation • Check claim status, reason code explanation and claims pending and mailing addresses • Update facility/practice demographic data (except TIN) • Check credentialing status or request for participation inquiries • Check appeal or claim project submission process information • Check care notification process information • Check privacy practice information
Provider Relations	uhc.com → contact us	• Physician and Hospital Advocates are for participating providers holding current contracts with UnitedHealthcare. Both roles are externally focused. • These advocates are local market and field representatives who are navigational specialists who assist providers with services, product offerings and chronic issues and are trusted advisors on industry best practices.

Commercial & Medicare Products		
Resource	**Where to go**	**What you can do there**
Advance Notification, Admission Notification, & Prior Authorization	UnitedHealthcareOnline.com or call Enhanced Voice Portal at (877) UHC-3210 (842-3210). See Customer's health care ID card for Customer care contact information	• Notify us about the procedures and services outlined in the *Notification Requirements* section of this Guide • Communicate with us regarding utilization management issues
Erickson Advantage® (A UnitedHealthcare Medicare Advantage network product for residents of Erickson Retirement Communities)	See Customer's health care ID card for Customer care contact information	• Inquire about benefits and services as indicated in this Guide, including *Notification Requirements*
Pharmacy Services (For Commercial Customers only)	UnitedHealthcareOnline.com Phone: (877) 842-1508 Fax: (877) 842-1435 Fax: (888) 327-9791	• View the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) by drug • Request a copy of the PDL • Call for medications requiring notification • Fax for easy Rx service
Pharmacy Services (For Medicare Advantage Customers only)	Go to securehorizons.com/Search the drug list Fax: (877) MDRXFAX (637-9329) Go to evercarehealthplans.com → prescription_drug_coverage Phone: (800) 711-4555 Fax: (800) 527-0531 Fax: (800) 853-3844 Phone: (866) 798-8780, Option 2	• View the SecureHorizons Formulary or request a copy • View the Evercare Formulary • View the UnitedHealthcare Personal Care Plus Formulary • Request a prior authorization • Submit request for oral medications • Submit request for injectable medications • Request information on the Medicare Medication Management Program
Behavioral Health Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's behavioral health benefits
Vision Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's vision benefits
Transplant Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's transplant benefits
Customer Care	See Customer's health care ID card for Customer care contact information	• Obtain information for services as indicated in this Guide
Electronic Payments and Statements (EPS)	UnitedHealthcareOnline.com (866) UHC-FAST (842-3278), Option 5	• Sign up for EPS • Call for questions or issues with EPS
Outpatient Radiology Notification & Authorization Submission and Status	UnitedHealthcareOnline.com Phone: (866) 889-8054 Fax: (866) 889-8061	• Notify us of certain radiology procedures as described in the *Outpatient Radiology Notification* and the *Outpatient Radiology Prior Authorization* section of this Guide
Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers contracted with OptumHealth Physical Health	myoptumhealthphysicalhealth.com Phone: (877) 842-3210	• Verify benefits and eligibility • Check Utilization Review process requirements
Cardiology Notification Submission & Status	UnitedHealthcareOnline.com Phone: (866) 889-8054 Fax: (866) 889-8061	• Notify us of certain inpatient, outpatient, and office-based cardiology procedures as described in the *Cardiology Notification* section of this Guide

For information on UnitedHealthcare Medicare Advantage products and services administered through **Oxford**, indicated by OHP on the Customer ID card, go to oxfordhealth.com.

For information on UnitedHealthcare Medicare Advantage products and services administered through **PacifiCare**, indicated by the PHS on the Customer ID card, go to pacificare.com.

For information on UnitedHealthcare Medicare Advantage products and services administered through **UnitedHealthcare**, as indicated by the UHC on the Customer ID card, go to UnitedHealthcareOnline.com.

Health care identification (ID) cards

UnitedHealthcare Customers receive a health care ID card containing information needed for you to submit claims. Information may vary in appearance or location on the card due to payer or other unique requirements. However, cards display essentially the same information (such as claims address, copayment information, telephone numbers such as those for Customer care and Advance Notification) and are viewable on UnitedHealthcareOnline.com in the Patient Eligibility section. Click on the "View Patent's ID card" link located in the Patient Search results section of the Eligibility Detail page.

Please check the Customer's health care ID card at each visit and keep a copy of both sides of the card for your records.

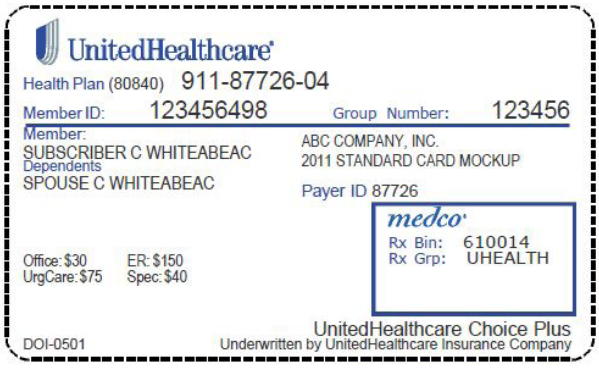
Checking health care benefit eligibility and copayment using the UnitedHealthcare health care ID swipe card at the time of service

UnitedHealthcare uses a 3-track card reader for checking health care eligibility and copayment information. The 3-track card reader can be used in conjunction with UnitedHealthcareOnline.com. Swipe the Customer's health care ID card to access the Customer's Personal Health Record, verify eligibility, submit a claim and perform other administrative transactions. UnitedHealthcare uses the national WEDI (Workgroup for Electronic Data Interchange) card standards for our Customer ID cards.

UnitedHealthcare has arranged a discounted 3-track card reader purchase price for physicians and health care professionals in the network, through a preferred distributor – BayScan Technologies. To order your reader(s), contact BayScan directly at (877) 229-7226 or at bayscan.com. Indicate that you are part of the UnitedHealthcare Network and supply your TIN to receive the discounted price when ordering.

As an additional resource, we have created a Swipe Health Care ID Cards Quick Reference, which can be found at UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Health Care ID Card Swipe Technology. This resource will enable you to learn more about how the UnitedHealthcare Medical - Rx ID card and integrated Financial & Medical - Rx ID card can simplify your transaction entry and accelerate payments.

Sample health care ID card



Medicare Advantage health care ID cards

In order to help identify those Customers associated with our Medicare Advantage products, please go to the following provider website for ID card guides: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → 2010 UnitedHealthcare Medicare Solutions Physician/Provider Information → Scroll to the "Benefit Plan Name Overviews" section at the bottom of the page.

Our products

Commercial products

This table provides information about some of the most common UnitedHealthcare products (your agreement with us may use "benefit contract types" or "benefit plan types" or a similar term to refer to our products). Visit UnitedHealthcareOnline.com for more information about our products in your area. Medicare and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in these products. If a Customer presents an ID card with a product name with which you are not familiar, please contact Customer care at the number on the back of the Customer's health care ID card. This product list is provided for your convenience and is subject to change over time.

Product Name	How do Customers access physicians and health care professionals?	Is the treating physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Choice and Choice Plus and CORE Choice and CORE Choice Plus	Customers can choose any network physician or health care professional without a referral and without designating a primary physician.* Choice Plus provides out-of-network benefits,** Choice does not (except for emergency).	Yes, on selected procedures. See guidelines in *Notification Requirements* section.
UnitedHealthcare Select and Select Plus	Customers choose a primary physician from the network of physicians for each family member. The primary physician coordinates their care.* Select Plus provides out-of-network benefits,** Select does not (except for emergency).	Yes, on selected procedures. See guidelines in *Notification Requirements* section.
UnitedHealthcare Options PPO	Customers can choose any network physician or health care professional without a referral and without designating a primary physician.* Options PPO provides out-of-network benefits.**	No. Customers are responsible for notifying us at the phone number on their health care ID card, as described under the Customer's benefit plan. Please refer Customer's to Customer Care for questions about their responsibilities. In Colorado, yes, on selected procedures. See guidelines in *Notification Requirements* section.
UnitedHealthcare Indemnity	Customers can choose any physician or health care professional.*	No. Customers are responsible for notifying us at the phone number on their health care ID card. Please refer Customers to Customer Care for questions about their responsibilities.

* Physicians and health care professionals must be licensed for the health services provided and the health care services provided must be covered under the Customer's benefit contract.

** The benefit level for non-emergency services from out-of-network physicians and other providers will generally be less than for services from network physicians and other providers.

Definity℠

Consumer-Driven Health Plans

UnitedHealthcare offers consumer-driven health plans to our Customers under the Definity name. These products may be identified via the health care ID card or by looking up your patient's eligibility information at UnitedHealthcareOnline.com. The Definity products each include three major components:

1. Traditional medical insurance that includes preventive care not charged against the deductible;
2. A Health Reimbursement Account (HRA) or Health Savings Account (HSA) for routine health care expenses; and
3. Educational tools and other support resources designed to positively impact consumer behavior and health care choices.

Definity HRA fast facts

- The Definity HRA plan's medical benefit includes a deductible, but enrollees typically use their HRA to pay for out-of-pocket expenses before they meet the deductible. The HRA is a type of medical savings account that is most often funded by the employer.
- The Definity HRA plan includes an enrollee out-of-pocket maximum. Once the maximum is met, the plan provides 100% reimbursement for covered services, including pharmacy benefits.
- Definity HRA enrollees are encouraged to access routine preventive care, so eligible services are covered under the basic medical benefit and are not subject to the deductible.

Definity HSA fast facts

- The Definity HSA plan's medical benefit includes a deductible, but enrollees can use their HSA to pay for out-of-pocket expenses before they meet the deductible. The HSA is a type of medical savings account that is most often funded by the employee.
- If Definity enrollees do not have sufficient funds in their HSA, or choose to save those funds for a later date, they pay any remaining plan deductible and coinsurance out-of-pocket. The HSA belongs to the account holder even if he or she changes employers, and the Internal Revenue Service allows annual deposits that can equal the plan's deductible.
- The Definity HSA plan includes an enrollee out-of-pocket maximum. Once the maximum is met, the plan provides 100% reimbursement for covered services, including pharmacy benefits.
- Definity HSA enrollees are encouraged to access routine preventive care, so eligible services are covered under the basic medical benefit and are not subject to the deductible.

Medicare Advantage products

This table provides information about some of the most common UnitedHealthcare Medicare Advantage products for individuals and employer group retirees. Visit AARPMedicarePlans.com, securehorizons.com, evercarehealthplans.com, UHCDualComplete.com or UnitedHealthcareOnline.com for more information about our Medicare Advantage products in your area. If a Customer presents a health care ID card with a product name with which you are not familiar, please contact the Enhanced Voice Portal at (877) 842-3210, or the phone number on the back of the Customer's health care ID card. This product list is provided for your convenience and is subject to change at any time.

Product name	**HMO and HMO-POS plans under the SecureHorizons, UnitedHealthcare or AARP® brands:** • MedicareComplete • MedicareComplete Essential • MedicareComplete Plus • MedicareComplete Plus Essential	**Local PPO and Regional RPPO plans under the SecureHorizons, UnitedHealthcare or AARP® brands:** • MedicareComplete Choice • MedicareComplete Choice Essential	**Dual Special Needs Plans:** **UnitedHealthcare Dual Complete** • Evercare Plan DH • Evercare Plan DH-POS • Evercare Plan DH-U • Evercare Plan DP • Evercare Plan RDP • UnitedHealthcare Personal Care Plus
Customer's Eligibility	Customers who are Medicare eligible.	Customers who are Medicare eligible.	Customers who are Medicare and Medicaid eligible.
How do Customers access physicians and health care professionals?	Customers choose a primary physician from the network of physicians to coordinate their care. MedicareComplete Plus HMO-POS plans provide out-of- network coverage for some covered benefits.*** MedicareComplete and MedicareComplete Essential HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	In most plans, Customers choose a primary physician from the network of physicians to coordinate their care. MedicareComplete Choice PPO plans provide out-of-network coverage for all benefits also covered in-network.***	Customers choose a primary physician from the network of physicians to coordinate their care. Evercare Plan DP, RDP and DH-POS provide out-of-network coverage.*** Evercare Plan DH does not except for emergency services.
Does a primary physician have to make a referral to a specialist?	A referral may or may not be required to see a specialist depending on the plan.** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.	No. A referral is not needed.	A referral may or may not be required to see a specialist depending on the plan.** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.
Is the treating physician and/or facility required to give notice when providing certain services?	Yes. See guidelines in the *Notification Requirements* section.	Yes. See guidelines in the *Notification Requirements* section.	Yes. See guidelines in the *Notification Requirements* section.

** Physicians in both the St. Louis, MO market and the Miami-Dade County, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.

*** The benefit level for non-emergency services from non-network physicians and other providers will generally be less than that for services from network physicians and other providers.

Product name	Institutional Special Needs Plans under the UnitedHealthcare or Evercare brands: Plan IH Plan IH-POS Plan IP	Erickson Advantage	Chronic Special Needs Plans under the UnitedHealthcare or Evercare brands: Plan MP Plan MH Plan MH-POS Evercare Plan RMP
Customer Eligibility	Customers who are Medicare eligible and reside in a contracted institutional setting.	Customers who are Medicare eligible and reside in an Erickson Retirement community.	Customers who are Medicare eligible and have one or more specific long term illness(es).
How do Customers access physicians and health care professionals?	Customers choose a primary physician from the network of physicians to coordinate their care. Plan IP and IH-POS provides out-of-network coverage.*** Evercare Plan IH does not except for emergency services.	Customers are assigned a primary physician from the Erickson Health Medical Group℠ network of physicians. The primary physician coordinates their care. Erickson Advantage provides out-of-network coverage.***	Customers choose a primary physician from the network of physicians to coordinate their care. The MH HMO plan does not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.
Does a primary physician have to make a referral to a specialist?	No. A referral is not needed.	No. A referral is not needed.	A referral is required to see a specialist. For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.
Is the treating physician and/or facility required to provide notice when providing certain services?	Yes. See guidelines in the *Notification Requirements* section.	Yes. Providers should call the Erickson Member Service's telephone number located on the Customer's ID card.	Yes. See guidelines in the *Notification Requirements* section.

Product Name	MedicareComplete Group Retiree (HMO and HMO-POS) plans under the SecureHorizons, UnitedHealthcare or AARP® brands	MedicareComplete Group Retiree (PPO and RPPO) plans under the SecureHorizons, UnitedHealthcare or AARP® brands	UnitedHealthcare Group Retiree Medicare Advantage (PPO)
Customer Eligibility	Customers who are Medicare eligible and meet employer's requirements.	Customers who are Medicare eligible and meet employer's requirements.	Customers who are Medicare eligible and meet employer's requirements.
How do Customers access physicians and health care professionals?	Customers choose a primary physician from the network of physicians. The primary physician coordinates their care. MedicareComplete (POS) provides out-of-network coverage for some covered benefits.*** MedicareComplete HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	Customers may choose a primary physician from the network of physicians. If a primary physician is chosen, the primary physician coordinates their care. MedicareComplete (PPO and RPPO) provide out-of-network coverage.***	Customers are not required to choose a primary physician from the network of physicians.
Does a primary physician have to make a referral to a specialist?	A referral may or may not be required to see a specialist based on service area.** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.	No. A referral is not needed.	No. A referral is not needed.

** Physicians in both the St. Louis, MO market and the Miami-Dade County, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.

*** The benefit level for non-emergency services from non-network physicians and other providers will generally be less than that for services from network physicians and other providers.

Is the treating physician and/or facility required to notify?	Yes. See guidelines in the *Notification Requirements* section.	Yes. See guidelines in the *Notification Requirements* section.	In-network providers are required to follow the policies, protocols and provisions of their contract and this Guide.

Medicare Select (AARP® Health)

What Is Medicare Select?

Medicare Select is a Medicare Supplement product available only to AARP members who reside within the service area of a hospital that participates in our Medicare Select network. It is a lower cost alternative to standardized Medicare Supplement coverage.

Responsibilities of Medicare Select insured Customers

To offer the plan at a lower premium, we require that Medicare Select insured Customers utilize a participating hospital for all inpatient and outpatient hospital services (except emergency care and services provided when Customers are outside of their service area). If Medicare Select insured Customers do not use a participating hospital for inpatient or outpatient hospital services, the services will not be covered unless required by law.

Hospital responsibilities

Participating hospitals agree to a reduced/waived reimbursement of Medicare's Part A In-Hospital deductible. Cost savings associated with hospitals' reduction/waiver of Medicare's Part A In-Hospital deductible are passed on to Medicare Select insured Customers in the form of lower premium cost.

To submit a Medicare Part A or Part B Intermediary claim for a Medicare Select Customer, mail a copy of the standard Centers for Medicare and Medicaid Services (CMS) billing form along with a Medicare Explanation of Benefits or Medicare Remittance Advice to:

UnitedHealthcare Claim Division
P.O. Box 740819
Atlanta, GA 30374-0819

Note: Medicare Part B claims billed to a Medicare carrier are, in most cases, received electronically from the Medicare carrier.

To promote timely processing on all claim submissions, follow standardized Medicare billing practices. Be sure to include the 11-digit insured AARP membership number on the standard CMS billing form.

What does Medicare Select cover in addition to Part A In-Hospital deductible?

Select Plans C & F

- In-Hospital Part A coinsurance for days 61 through 90 in a Medicare Benefit Period
- In-Hospital Part A coinsurance for days in which Lifetime Reserve days are used
- Medicare Part A eligible expenses for a Lifetime Maximum of 365 days after all Medicare Part A benefits are exhausted
- Medicare Part B coinsurance (generally 20% of Medicare's approved amount)
- Medicare Part B deductible amount applied each calendar year
- Skilled Nursing Facility stays - the daily coinsurance amount for days 21 to 100 for stays eligible under Medicare
- Medicare Parts A and B Blood deductible: Charge incurred for the first 3 pints of unreplaced blood furnished in a calendar year
- Foreign Travel Emergency
- Hospice - the Medicare copayments and coinsurance for Hospice Care and Respite Care

Select Plan F only

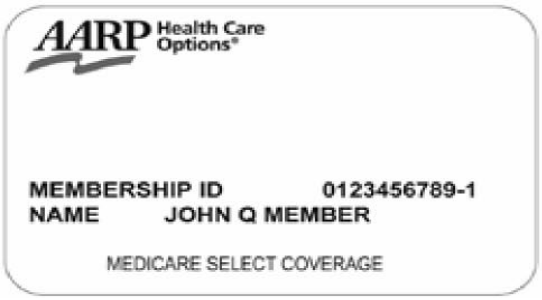
- Medicare Part B Excess Charges for Medicare approved services

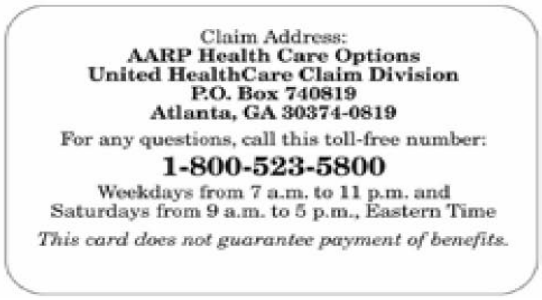
What advantages does Medicare Select give to participating hospitals?

- Participating in Medicare Select will likely increase the hospital's access to AARP® insured members because to get the most out of their coverage, Medicare Select members must go to a participating hospital. Only participating hospitals will be included in AARP Medicare Select Plan marketing materials within their service area.
- By participating in Medicare Select, the hospital will be limiting its financial exposure to non-payment of the Medicare deductible and coinsurance amounts for inpatient and outpatient hospital services. Under the AARP Medicare Select Plans C and F, neither inpatient hospital stays nor outpatient hospital services will be covered unless they are received at a participating hospital. The participating hospital agrees to a reduced reimbursement of Medicare's Part A deductible. UnitedHealthcare reimburses all other Medicare Part A eligible expenses up to the 365-day limit, which are not paid for by Medicare, as well as all Medicare Part B eligible expenses not paid for by Medicare. If a non-participating hospital provides inpatient or outpatient services to a Medicare Select insured member, the services will not be covered.
- Hospitals can expect to receive claim payment in a timely fashion, as more than 90% of all claims are processed within 10 business days. This may reduce hospital collection efforts.
- This product meets "Safe Harbor" requirements under Federal Anti-Kickback legislation.

For more information on Medicare Select and other AARP Medicare Supplement product offerings, contact Customer Service at (800) 523-5800 (para Español (800) 822-0246). For hearing impaired members (TTY), call 711.

Sample AARP Medicare Select Plan ID card





Notification requirements

Standard notification requirements (for most states*)

Information gathered about planned Customer care supports the care coordination process. UnitedHealthcare's notification requirements are designed to effectively gather the pertinent information in a timely manner.

- Physicians, Health Care Professionals and Ancillary Providers are responsible for Advance Notification for certain planned services.
- Facilities are not responsible for Advance Notification, but are responsible for Admission Notification for inpatient admissions described in this Guide.
- Certain advance outpatient imaging services described in this Guide are subject to Notification by the ordering provider and confirmation by the rendering provider.
- NOTE: Please see the description of and protocols for this in the *Outpatient Radiology Notification for Medicare*

* For information showing each state's status, please refer to UnitedHealthcareOnline.com → Tools and Resources → Policies and Protocols → Advance and Admission Notification. If additional states are added to those subject to the standard requirements described here, you will receive a written notice if you participate in that state. Please refer to UnitedHealthcareOnline.com for state-specific variations of this Protocol.

Advantage Customers section of this Guide.

- The Advance Notification protocols outlined in this section do not apply to the required notification for certain advanced radiology procedures for specified Commercial plans or to the required notification for certain Cardiology procedures for certain Commercial and Medicare plans. Instead of Notification Requirements, our Medicare Advantage Plans require Prior Authorization for certain advanced radiology procedures. The requirements and protocols for those procedures and the plans to which they apply are addressed in the sections entitled, Outpatient Radiology Notification, Radiology Prior Authorization Program for Medicare Advantage Customers and Cardiology Notification Program.
- Notify us at UnitedHealthcareOnline.com → Notifications → Notification Submission. We will accept daily composite census logs for inpatient admissions, with complete and relevant information, via fax. If you do not have electronic access, please call us at the number on the back of the Customer's health care ID card.

Advance Notification requirements

(Applies to physicians, health care professionals and ancillary providers only. This section does not apply to Notification for Outpatient Radiology services).

- Notification is required only for those planned services on the Advance Notification List.
- Certain services may not be covered within an individual Customer's/member's benefit plan, regardless of whether Advance Notification is required.
- The list of services requiring Advance Notification includes both inpatient and outpatient services.
- The Advance Notification List applies to Customers/members with a plan that requires Notification. Once you contact us, we will determine and communicate whether a coverage review is required. It is important that you and the Customer/member are fully aware of coverage decisions before services are rendered.
- Notification should be submitted as far in advance of the planned service as possible to allow for coverage review. Notification is required at least 5 business days prior to the planned service date (unless otherwise specified within the Advance Notification List). Note that Notification for home health services is required within 48 hours after the physician's order.
- See Section on Outpatient Radiology Notification for further information about notification requirements
- Advance Notifications must contain the following information associated with the planned service:
    - Customer/member name and Customer/member ID number
    - Ordering physician or health care professional name and TIN or National Provider Identification (NPI)
    - Rendering physician or health care professional name and TIN or NPI
    - ICD-9-CM (or its successor) diagnosis code for the diagnosis for which the service is requested
    - Anticipated date(s) of service
    - Type of service (procedure code(s) and volume of service (when applicable))
    - Facility name and TIN or NPI where service will be performed (when applicable)
    - Original start date of dialysis (End Stage Renal Disease (ESRD) only)

Please refer to the individual services listed in the Advance Notification List below for specific, additional required information. Additional information we may reasonably request in order to make the necessary determination.

Admission notification (applies to facilities only)

- Admission Notification is required for the following admission types:
    - All planned/elective admissions for acute care
    - All unplanned admissions for acute care

  - All Skilled Nursing Facility (SNF) admissions
  - All admissions following outpatient surgery
  - All admissions following observation
  - All newborns admitted to Neonatal Intensive Care Unit (NICU)
  - All newborns who remain hospitalized after the mother is discharged (within 24 hours of the mother's discharge)
- Admission Notification must be received within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.
- Admission Notification by the facility is required even if Advance Notification was supplied by the physician.
- Admission Notifications must contain the following details regarding the admission:
  - Customer/member name and Customer/member ID number
  - Facility name and TIN or NPI
  - Admitting/attending physician name and TIN or NPI
  - Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code
  - Actual admission date
- For emergency admissions when a Customer/member is unstable and not capable of providing coverage information, the facility should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances. We will flag the case for payment without any notification-related reimbursement adjustments.
- For all admissions: If Admission Notification is provided after 24 hours as described above, but within 72 hours after admission, the reimbursement will be 50% of the average daily payment rate for each day preceding Admission Notification and 100% thereafter (not applicable to DRG/case rate contracts without outlier provisions). The average daily payment rate will be calculated by dividing the contracted rate for the admission by the admission length of stay.
- For all admissions: if Admission Notification is provided after 72 hours or not at all, the reimbursement will be 50% of the contracted rate for the entire admission (applicable to all contracts, regardless of payment methodology).

Advance Notification list

The following list of Advance Notification requirements for physicians, other healthcare professionals and ancillary providers does not indicate or imply coverage. Coverage is determined in accordance with the Customer's/member's benefit plan.

This table provides information about some of the most common UnitedHealthcare products that have an Advance Notification requirement. For additional product information in your area, visit UnitedHealthcareOnline.com or refer to the "Our Products" section of this Administrative Guide. Medicare and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in these products. This product list is provided for your convenience and is subject to change over time.

If a Customer/member presents an ID card with a product name with which you are not familiar, please contact Customer care at the number on the back of the Customer's/member's health care ID card.

Our products	
Commercial	Choice, Choice Plus , CORE Choice, CORE Choice Plus, Select, Select Plus, Catalyst, Edge
Medicare Advantage	Please refer to the *Our Medicare Advantage products* section of this Guide.

Advance notification submission methods		
UnitedHealthcare Online	UnitedHealthcareOnline.com	
Phone	See Customer's/member's health care ID card for the phone number unless specified differently below.	
Fax	Commercial Customers/members:	(866) 756-9733
Fax	SecureHorizons Customers/members:	(800) 676-4798
Fax	Evercare and UnitedHealthcare Personal Care Plus Customers/members (Except Erickson Advantage):	(800) 538-1339
Phone	Erickson Advantage	Call Erickson Campus Member Service Representative

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Accidental Dental Services	• Ancillary Providers	• Commercial • Medicare Advantage	• Erickson Advantage Customers/members	Dental services that meet the following criteria may be eligible for medical coverage depending on the Customer's/member's benefit plan: • Date of initial contact for dental evaluation is within plan limits following the accident. • Initiation of definitive treatment services within guidelines. • Estimated completion date of treatment services, if known. • Certification that the injured tooth was a sound natural tooth. This does not apply to dental services that are excluded under the Customer's/member's benefit plan. Dental implants are not covered under most plans.
Ambulance Transportation (non urgent)	• Ancillary Providers	• Commercial • Medicare Advantage	• No applicable exclusions	Non-urgent ambulance transportation between specified locations for Customers/members who cannot travel by other forms of transportation.

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Bariatric Surgery	• Servicing Providers	• Commercial • Medicare Advantage	• Erickson Advantage Customers/members	Bariatric Surgery and specific obesity-related services (as defined by the ICD-9-CM and CPT® codes below, or their successor codes) whether scheduled as inpatient or outpatient. (CPT is a registered trademark of the American Medical Association.) ICD-9-CM (or its successor): 44.31, 44.38, 44.39, 44.68, 44.95, 44.96, 44.98 CPT: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999 As a reminder, bariatric surgery and other obesity services are not covered in some benefit plans. In some situations, there is a Center of Excellence (COE) requirement for coverage of bariatric surgery/ services. Medicare coverage is based on the guidelines outlined by the CMS. For additional information, consult the CMS National coverage Determination Database.
Behavioral Health Services	• Servicing Providers	• Commercial • Medicare Advantage	• Erickson Advantage Customers/members	Many of our benefit plans only provide coverage for behavioral health services through a designated behavioral health network. Therefore, it is important for you to call the number on the Customer's/ member's health care ID card when referring for any mental health or substance abuse/substance use services.
BRCA Genetic Testing Program	• Ordering providers provide notice to the Ancillary Providers (laboratories) who in turn provide notice to UnitedHealthcare	• Commercial	• Medicare Advantage Customers/members	BRCA 1 and BRCA 2 (Breast Cancer Susceptibility) are genetic tests performing DNA sequencing to look for known gene mutations that are associated with the development of breast and ovarian cancer. BRCA testing requires an advance notification prior to performing the DNA sequencing. The ordering provider provides notice to the laboratory which would conduct the test, and the laboratory in turn provides notice to UnitedHealthcare. HCPCS: S3818-S3820, S3822-S3823 Genetic counseling is a service that Customers/ members may elect to receive if they would like a board-certified genetic counselor to explain the BRCA testing, and help them make decisions about the clinical indications for such testing. Once we receive notification for BRCA testing from the provider, Customers/members will receive a letter outlining the available genetic counseling service and how to access that service if they choose. As a reminder, genetic testing and/or genetic counseling services are not covered in some benefit plans. Please note: Medicare coverage for genetic testing is based on the guidelines outlined by the CMS. For additional information, consult the CMS National Coverage Determination Database. For services listed in this section, fax to (866) 756-9733.

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Cancer Treatment Initiation	• Servicing Providers	• Commercial	• Medicare Advantage Customers/members	Initiation of cancer treatment for a diagnosis other than skin cancer or cervical cancer. Notification is required to assist UnitedHealthcare in identifying Customers/members that may be eligible for additional UnitedHealthcare programs and services. For services listed in this section, call OptumHealth Cancer Resource Services directly at (866) 936-6002.
Cardiology Notification Program (See additional requirements in the *Cardiology Notification* section of this Guide)	• Servicing Providers	• Commercial • Medicare Advantage Customers/ members enrolled in Secure-Horizons and Evercare benefits plans	• Erickson Advantage Customers/members	Notification required for participating physicians for inpatient, outpatient, and office-based diagnostic catheterizations and electrophysiology implants prior to performance. Physician-to-physician review may be required, based on the Cardiology Notification Program Clinical Criteria, to help support physicians in their decision-making process. Notification may be submitted by the rendering physician in one of three ways: • Online via UnitedHealthcareOnline.com → Notifications → Cardiology Notification Submission and Status • By calling (866) 889-8054 (Direct Line), or using the Enhanced Voice Portal line at (877) 842-3210 and selecting the Cardiac Option • By faxing (866) 889-8061 (A fax form is available for download at UnitedHealthcareOnline.com → Notifications → Cardiology Notification Submission and Status) For additional details, including a list of the CPT codes for which notification is required, please visit UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program.
Capsule Endoscopy	• Servicing Providers in Arizona	• Commercial (Applies only to Arizona providers)	• Commercial (providers outside of Arizona) • Medicare Advantage	Non-invasive procedure in which an ingested capsule containing a miniature video camera takes a video recording of the mucosal lining of the esophagus or small bowel as it moves through the gastrointestinal tract.
Chiropractic Services	• Servicing Provider	• Commercial • Medicare Advantage	• Erickson Advantage Customers/members	Many of our benefit plans only provide coverage for chiropractic services through a designated arrangement subject to a benefit review. Therefore, it is important for you to call the number on the Customer's/member's health care ID card when referring for any chiropractic services.
Cochlear Implants	• Servicing Providers in Arizona	• Commercial (Applies only to Arizona providers)	• Commercial (providers outside of Arizona) • Medicare Advantage	Surgically-placed devices used to improve sound recognition.

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Congenital Heart Disease	• Servicing Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	Congenital Heart Disease-related services For services listed in this section, call OptumHealth directly at (888) 936-7246 or the number on the back of the health care ID card. ICD-9-CM (or its successor): 745.0 through 747.81 CPT: 33251, 33254, 33255, 33256, 33257, 33258, 33259, 33261, 33404, 33414, 33415, 33416, 33417, 33476, 33478, 33500, 33501, 33502, 33503, 33504, 33505, 33506, 33507, 33600, 33602, 33606, 33608, 33610, 33611, 33612, 33615, 33617, 33619, 33641, 33645, 33647, 33660, 33665, 33670, 33675, 33676, 33677, 33681, 33684, 33688, 33690, 33692, 33694, 33697, 33702, 33710, 33720, 33722, 33724, 33726, 33730, 33732, 33735, 33736, 33737, 33750, 33755, 33762, 33764, 33766, 33767, 33768, 33770, 33771, 33774, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33786, 33788, 33802, 33803, 33820, 33822, 33840, 33845, 33851, 33852, 33853, 33917, 33920, 33924, 93501, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93561, 93562, 93580, 93581
Durable Medical Equipment (DME) – greater than $1,000	• Ancillary Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	In general, we require notification for DME with a retail purchase cost or a cumulative retail rental cost over $1,000. Prosthetics are not DME (see separate *Prosthetics and Orthotics notification requirement* in this grid). Some payer groups may have different DME notification requirements imposed upon Customers/ members through their benefit plans.

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
End Stage Renal Disease/ Dialysis Services	• Ancillary Providers	• Commercial • Medicare Advantage	• Erickson Advantage Customers/members	Services for the treatment of End Stage Renal Disease (ESRD), including outpatient dialysis services (as defined by, but not limited to, the revenue and CPT codes below), require notification. No notification is required for end stage renal disease when a Medicare Customer/member travels outside of the service area. CPT: 90935, 90937, 4052F, 4054F – hemodialysis 90945, 90947, 4055F – peritoneal 90963 – 90970 – ESRD 90989 – patient training, completed course 90993 – patient training, per session 90999 – unlisted dialysis procedure, inpatient or outpatient Revenue Codes: 304 – Non routine Dialysis 800 – 804, 809 – Renal Dialysis 820 – 825, 829 – Hemo/op or home 830 – 835, 839 – Other outpatient/peritoneal dialysis 840 – 845, 849 – Capd/op or home 850 – 855, 859 – Ccpd/op or home 880 – 882, 889 – Dialysis / misc For the most current listing of UnitedHealthcare contracted dialysis facilities, please refer to our online provider directory at UnitedHealthcareOnline.com or call us at (877) 842-3210. In an effort to maximize Customer/member benefit coverage and lifetime, maximum limits, we ask that you refer to UnitedHealthcare contracted dialysis facilities whenever possible. Note that your agreement with us may include restrictions on referring Customers/members outside the UnitedHealthcare network.
Home Health Care Services	• Ancillary Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	All services which are based in the home including, but not limited to: • Enteral Formula • Home Infusion Therapy • Home Health Aid (HHA) • Occupational Therapy (OT) • Physical Therapy (PT) • Private Duty Nursing (T1000) • Respiratory Therapy (RT) • Skilled Nursing (SNV) • Social Worker (MSW) • Speech Therapy (ST)
Hospice (Inpatient)	• Ancillary Providers	• Commercial	• Medicare Advantage	Inpatient Hospice services only.
Hyperbaric Oxygen Treatment	• Servicing Providers in Arizona	• Commercial (Applies only to Arizona providers)	• Commercial (providers outside of Arizona) • Medicare Advantage	Non-emergent hyperbaric oxygen treatments require advanced notification and benefit review

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Intensity Modulated Radiation Therapy (IMRT)	• Servicing Providers	• Commercial	• Medicare Advantage	IMRT services require advance notification CPT: 77418 - intensity modulated treatment delivery, single or multiple fields / arcs, per treatment session 0073T – compensator-based beam modulation treatment delivery Fax the completed UnitedHealthcare IMRT Data collection form and all supporting information to (866) 756-9733. The UnitedHealthcare IMRT Data collection form can be found at UnitedHealthcareOnline.com.
Joint Replacement	• Servicing Providers in Arizona	• Commercial (Applies only to Arizona providers)	• Commercial (providers outside of Arizona) • Medicare Advantage	Joint replacement procedures in addition to total hip and knee.
MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroid	• Servicing Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	MR-guided focused ultrasound procedures and treatments, as defined by but not limited to: CPT: 0071T and 0072T MR-guided focused ultrasound is a covered service for certain benefit plans, subject to the terms and conditions of those benefit plans, which generally are as follows: • The physician and/or facility must confirm coverage of the service for the Customer/member. • The hospital and or/facility must be contracted with UnitedHealthcare. UnitedHealthcare enrollees have no out-of-network benefits for MRgFUS. • The Customer/member must consent in writing to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective. • The Customer/member must agree in writing to hold UnitedHealthcare harmless if the enrollee is dissatisfied with the results of treatment. • The consent form can be found at: UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Medical & Drug Policies and coverage Determination Guidelines. • The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare. • The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use.
Orthopedic and Spine Surgeries	• Servicing Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	Inpatient admissions for spinal surgeries, total knee replacements and total hip replacements require advance notification at least 5 days prior to the admission. Advance Notification can be submitted online at UnitedHealthcareOnline.com.
Outpatient Spine Surgeries	• Servicing Providers in Arizona	• Commercial (Applies only to Arizona providers)	• Commercial (providers outside of Arizona) • Medicare Advantage	Outpatient Spinal Surgeries (in addition to Inpatient Spinal Surgeries).

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Part B Occupational Therapy (OT), Speech Therapy (ST) or Physical Therapy (PT)	• Servicing Providers	• Medicare Advantage • Erickson Advantage Customers/ members residing in a long term care facility.	• Commercial	Part B OT, ST or PT provided in a SNF.
Physical Therapy/ Occupational Therapy (PT/OT)	• Servicing Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	Many of our benefit plans only provide coverage for PT/OT through a designated arrangement subject to a benefit review. Therefore, it is important for you to call the number on the Customer's/member's health care ID card before referring for any PT/OT services.
Pregnancy, Healthy Pregnancy Notification	• Servicing Providers	• Commercial • Medicare Advantage	• Erickson Advantage Customers/members	Upon confirmation of pregnancy, a notification is required by physicians or other health care professionals who provide obstetrical care to a pregnant Customer/member for: ICD-9-CM (or its successor): V72.42 or any other diagnosis code related to pregnancy. Notification is required only once per pregnancy. Notification is not required for ancillary services such as ultrasound and lab work. If, after you have notified us of a pregnancy, you obtain information that would cause you to conclude that the Customer/member is no longer appropriate for a Healthy Pregnancy Program, for instance due to termination of the pregnancy, we ask that you notify us of that fact.
Prosthetic and Orthotic Services Greater than $1,000	• Servicing Providers	• Medicare Advantage	• Commercial	Prosthetic and orthotic services with a retail purchase cost or cumulative retail rental cost exceeding $1,000.

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Radiology Notification (See additional requirements in the *Outpatient Radiology Notification* section of this Guide)	• Ordering Providers for most products must provide notification; ordering providers for Medicare Advantage Plans must obtain prior authorization • Servicing Providers for most products must confirm notification has been provided;	• Commercial	• Medicare Advantage	For Commercial benefit plans, we require advance notification for the following defined set of advance outpatient imaging procedures: CT scan, MRI, MRA, PET scan, Nuclear Medicine, and Nuclear cardiology. The physician/health care professional ordering the imaging service is responsible for obtaining a notification number prior to scheduling the advance outpatient imaging procedures. Ordering physicians/health care professionals can obtain the required notification number by contacting UnitedHealthcare through any of the following: • Online: UnitedHealthcareOnline.com → Notifications → Radiology Notification & Authorization Submission and Status • Phone: (866) 889-8054 (Direct line), • Enhanced Voice Portal line: (877) 842-3210 and selecting the Radiology Option • Fax: (866) 889-8061 (A fax form is available to download at UnitedHealthcareOnline .com → Clinician Resources → Radiology → Radiology Notification & Authorization → Radiology Notification → Notification Resources: Modality-specific Fact Forms) Additional details regarding this notification requirement, including a list of the CPT codes for which notification is required are available online at: UnitedHealthcareOnline.com →Clinician Resources → Radiology → Radiology Notification → & Authorization → Radiology Notification → Notification Resources: Reference Materials
Radiology Prior Authorization (See additional requirements in the *Cardiology Notification* section of this Guide)	• Ordering Providers must provide notification and obtain authorization; • Servicing Providers must confirm notification has been provided and that an approved authorization is on file.	• Medicare Advantage	• Commercial • Erickson Advantage Customers/members	For Medicare Advantage benefit plans, UnitedHealthcare requires prior authorization for the following defined set of advance outpatient imaging procedures: CT scan, MRI, MRA, PET scan, Nuclear Medicine, and Nuclear Cardiology. The physician/health care professional ordering the imaging service is responsible for obtaining an authorization number prior to scheduling the outpatient imaging procedures. Ordering physicians/health care professionals can obtain the required authorization number by contacting UnitedHealthcare through any of the following: • Online: UnitedHealthcareOnline.com → Notifications → Radiology Notification & Authorization Submission and Status • Phone: (866) 889-8054 (Direct line), • Enhanced Voice Portal line: (877) 842-3210 and selecting the Radiology Option • Fax: (866) 889-8061 (A fax form is available to download at UnitedHealthcareOnline .com → Clinician Resources → Radiology → Radiology Notification & Authorization → Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Reference Materials) Additional details regarding this notification requirement, including a list of the CPT codes for which notification is required are available online at: UnitedHealthcareOnline.com →Clinician Resources → Radiology → Radiology Notification → & Authorization → Radiology Notification → Notification Resources: Reference Materials

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Reconstructive/ Potentially Cosmetic Procedures	• Servicing Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	Cosmetic Procedures are procedures or services that change or improve physical appearance, without significantly improving or restoring physiological function, as determined by us. Reconstructive Procedures are procedures or services that either treat a medical condition or improve or restore physiologic function. To confirm coverage, we require notification for such services whether scheduled as inpatient or outpatient, including but not limited to: • Ablation, Ligation, Vein Stripping – removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins • Blepharoplasty, upper lid – reconstructive procedures including repair of brow ptosis • Breast Reconstruction – reconstruction of the breast other than following mastectomy • Breast Reduction – removal of breast tissue in men or women other than mastectomy for cancer • Cranial remolding helmet – for treatment of congenital musculoskeletal deformities • Genioplasty - sliding, augmentation with interpositional bone grafts • Mastectomy for gynecomastia • Orthognathic Surgery – treatment of maxillofacial functional impairment • Palatopharyngoplasty – oral pharangeal reconstructive surgery, includes laser-assisted uvulopalatoplasty (laup) • Panniculectomy or Abdominoplasty– Excision, excessive skin and subcutaneous tissue (includes lipectomy) • Septoplasty – treatment of nasal functional impairment and septal deviation • Thoracoscopy – sympathectomy for treatment of hyperhidrosis
Referral for Out-of-Network Services	• Referring Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	Please note that your agreement with UnitedHealthcare may include restrictions on directing Customers/members outside the UnitedHealthcare network. Your patients who utilize non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses or no coverage. Notification is required when a network physician or health care professional directs a Customer/ member to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a Customer's/ member's benefit plan has benefits for out-of-network services.
Sleep Apnea Procedures and Surgeries	• Servicing Providers in Arizona	• Commercial (Applies only to Arizona providers)	• Commercial (providers outside of Arizona) • Medicare Advantage	Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea.

	Applies to:			
Procedures & services	**Notification required by**	**Plan inclusions**	**Plan exclusions & exceptions**	**Explanation**
Specific Medications as Indicated on the PDL	• Servicing Providers	• Commercial	• Medicare Advantage	Call (877) 842-1435 when prescribing medications that require notification. These medications are so designated on the Prescription Drug List (PDL). To view the Prescription Drug List (PDL), visit UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources, or call (877) 842-1508 to request a copy of our PDL. For additional information on our Medicare or Medicare Part D formularies and pharmaceutical management procedures, go to Securehorizons.com → search the drug list or for the most recent changes go to Securehorizons.com → search the drug list → view recent formulary changes. If you do not have internet access and would like to request a copy please contact the Enhanced Voice Portal at (877) 842-3210.
Transplant Services	• Servicing Providers	• Commercial • Medicare Advantage	• No Applicable Exclusions	For services listed in this section, call OptumHealth directly at (888) 936-7246 or the notification number on the back of the health care ID card. Request for transplant or transplant-related services prior to pre-treatment or evaluation, including the following list of CPT codes for Specifically Requested Transplantations:

BONE MARROW - Peripheral Stem Cell

38230	Bone marrow harvesting for transplantation
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions

HEART / LUNG

33930	Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

HEART

33940	Donor cardiectomy, with preparation and maintenance of allograft
33945	Heart transplant, with or without recipient cardiectomy
0051T	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy
0052T	Replacement or repair of thoracic unit of a total replacement heart system (artificial heart)
0053T	Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit

LUNG

32850	Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver)
32851	Lung transplant, single; without cardiopulmonary bypass
32852	with cardiopulmonary bypass
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854	with cardiopulmonary bypass

KIDNEY

50300	Donor nephrectomy, with preparation and maintenance of allograft, from cadaver donor, unilateral or bilateral
50320	Donor nephrectomy, open from living donor (excluding preparation and maintenance of allograft)
50340	Recipient nephrectomy
50360	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
50365	with recipient nephrectomy
50370	Removal of transplanted renal allograft
50380	Renal autotransplantation, reimplantation of kidney
50547	Laparoscopic donor nephrectomy from living donor (excluding preparation and maintenance of allograft)

PANCREAS

48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells
48550	Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation
48554	Transplantation of pancreatic allograft
48556	Removal of transplanted pancreatic allograft

LIVER

47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47136	Heterotopic, partial or whole, from cadaver or living donor, any age

INTESTINE

44132	Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor
44133	partial, from living donor
44135	Intestinal allotransplantation; from cadaver donor
44136	from living donor

Cardiology Notification Program (starting July 1, 2010; effective dates vary by state)

Except as noted below, the Cardiology Notification Program requirements in this protocol apply to all participating physicians ("Physicians") who perform diagnostic catheterizations and electrophysiology implant procedures on UnitedHealthcare Customers/members.

- This protocol applies to all Physicians rendering diagnostic catheterization and electrophysiology implant procedures including those Physicians who have received the UnitedHealth Premium® quality and efficiency of care designation.
- This protocol is a prior notification requirement, not a precertification, preauthorization or medical necessity determination. Notification under this protocol is required for services rendered in all settings (e.g., outpatient, inpatient, and office-based).
- ***Physicians should not delay emergency care to notify***. Physicians may request a notification number on an urgent basis if the Physician determines it to be medically required. A notification number will be issued for urgent requests within 3 hours of UnitedHealthcare receiving all required information. If the Physician determines that care must be provided before a notification number can be issued on an urgent basis, the services should be performed and the notification requested retrospectively following the *Retrospective Notification* process described below. Additionally, notification can be requested retrospectively for procedures performed during the course of an inpatient admission if the patient is admitted for a reason other than the procedures subject to this protocol. Retrospective Notification requests must be made within 14 calendar days of the service. Providers should follow the Retrospective Notification Process described below.
- Compliance with this protocol is required. Unless the entire notification process is completed (including a physician-to-physician discussion in some cases), a notification number will not be issued. Further, failure to complete the entire process may result in an administrative reimbursement reduction, individual claim line denial for the CPT codes subject to this protocol, and any action available under the terms of the rendering physician's participation agreement.
- The procedures subject to this notification requirement include:
    - Diagnostic catheterization procedures include, for example, coronary arteriogram, left heart catheterizations, and combined left-right heart catheterizations.
    - Electrophysiology implants include, for example, pacemaker and automated implantable cardio-defibrillators.
- A list of CPT codes that are subject to this notification requirement is available online at UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program → Important Program Information.

Rendering physician:

- To receive payment for services rendered, prior to performing the stated diagnostic catheterization or electrophysiology implant procedure, the rendering Physician must:
- Contact us and follow the notification process:
    - Online: UnitedHealthcareOnline.com → Notifications → Cardiology Notification Submission and Status
    - Phone: (866) 889-8054 (Direct Line), or using the Enhanced Voice Portal line at (877) 842-3210 and selecting the Cardiac Option
    - Fax: (866) 889-8061 (A fax form is available for download at UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program → Important Program Information)
- If the procedure requested for the Customer/member is not consistent with the Cardiology Notification Program Clinical Criteria or if further information is needed to assess the request, the rendering Physician (or their designee such as a covering physician, physician's assistant, or nurse practitioner) must participate in a physician-to-physician dialogue to discuss the clinical rationale for the request, provide additional clinical information as required and to

consider alternative approaches. Upon completion of the discussion, the rendering Physician (or their designee) will confirm the procedure ordered and a notification number will be issued. The rendering Physician maintains final decision authority for the performance of the procedure.

- Compliance with this notification protocol is required. A notification number will not be issued and an administrative reimbursement reduction and individual claim line denial for CPT codes subject to this protocol will apply to the rendering physician if the entire notification process (including a physician-to-physician discussion in a subset of cases) is not completed.
- Please note that notification is required of the rendering Physician. However, notification will be accepted on behalf of the rendering Physician by either the Physician's office staff or the facility if they have the relevant clinical information to notify for the procedure.

The information listed below may be requested at the time of the notification request:

Customer/Member information

- Customer/Member's UnitedHealthcare ID number
- Customer/Member's name, address and telephone number
- Customer/Member's group number
- Customer/Member's date of birth

Physician information

- Physician name, TIN, specialty, address, and telephone number
- The contact person at the rendering Physician's office

Procedure/clinical information

- The procedure being requested, with the CPT code(s)
- The diagnosis or "rule out" with the ICD-9-CM (or its successor) code(s)
- The Customer's/Member's symptoms, listed in detail, with severity and duration. Treatments that have been tried, including dosage and duration for drugs, and dates for other therapies.
- Dates of prior imaging studies performed
- Any other information that the physician believes will help in evaluating the request including, but not limited to, prior diagnostic tests, consultation reports, etc.

Note: The receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that notification was made. Medical coverage and payment authorization is a separate process determined by the Customer's/Member's benefit contract and the physician's participation agreement with UnitedHealthcare.

Urgent requests

- Physicians may request a notification number on an urgent basis if the Physician determines it to be medically required. A notification number will be issued for urgent requests within 3 hours of UnitedHealthcare receiving all required information. If the Physician determines that care must be provided before a notification number can be issued on an urgent basis, the services should be performed and the notification requested retrospectively following the *Retrospective Notification* process described below.

Retrospective notification process

- ***Physicians should not delay emergency care in order to notify***. If a diagnostic catheterization or electrophysiology implant procedure is required on an emergent basis, the service may be performed, and notification can be provided retrospectively.
- In order to ensure that patient care is not delayed while in the inpatient setting, the Retrospective Notification

Process is available for procedures performed during the course of an inpatient admission if the patient is admitted for a reason other than the procedures subject to this protocol. For example, if a patient is admitted for a reason (e.g., heart failure) other than the procedures subject to this program and it is determined during a cardiac consult that a diagnostic catheterization or electrophysiology implant is required, the physician should proceed with the procedure and submit the notification on a retrospective basis within 14 calendar days of the service. This Retrospective Notification Process does not apply to the facility's separate Admission Notification requirement.

- Retrospective Notification requests must be made within 14 calendar days of the service.
- Rendering Physicians should follow the same notification process outlined above for a standard request.
- Documentation must include an explanation as to why the procedure was required on an emergent basis.
- Claims submitted prior to the Retrospective Notification process being completed, will receive an automated denial for lack of notification; however, the claim will be reprocessed if Retrospective Notification is received within 14 calendar days of the service, and it meets criteria as an emergent procedure.

Products included

This program applies to Customers/members enrolled in UnitedHealthcare Choice, Choice Plus, Select and Select Plus benefit plans as well as Medicare Advantage Plans offered through the SecureHorizons® Evercare®, UnitedHealthcare and AARP® MedicareComplete® brands which are subject to the UnitedHealthcare Administrative Guide.

It is important to note that government plans for Medicare Customers are subject to this notification requirement.

Products/Customers excluded

This program does not apply to plans jointly offered by UnitedHealthcare and Harvard Pilgrim Health Care for Customers using the Harvard Pilgrim provider network. The program does not apply to Customers enrolled in Medicaid government plans such as *UnitedHealthcare Community Plan* (formally known as AmeriChoice®), or benefit plans issued or administered by any legal entities associated with any of the following affiliates: Oxford Health Plans, PacifiCare, M.D. Individual Practice Association, Inc. (M.D. IPA), Optimum Choice, Inc., MAMSI Life and Health Insurance, Neighborhood Health Partnership, River Valley, or Sierra. Customers of these plans are subject to the administrative guide, manual or supplement of that Affiliate. The existing requirements regarding notification, authorization and/or precertification for the above listed excluded entities remain in place and the process for authorization will not change.

State roll-out schedule

For information showing each state's participation status in this program, please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program. If additional states are added, you will receive a written notice if you participate in that state.

Please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program for the latest information on this program.

Outpatient Radiology Notification (for Commercial Customers only)

The Outpatient Radiology Notification requirements in this Protocol apply to all participating physicians, health care professionals, facilities and ancillary providers ("Physicians/Providers") that order or render Advanced Outpatient Imaging Procedures. Advanced Outpatient Imaging Procedures are: Computerized Axial Tomography (CT), Magnetic Resonance Image (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology.

This Protocol is a prior notification requirement, not a precertification, preauthorization or medical necessity determination. Notification under this Protocol is required for outpatient services only. Imaging services ordered during emergency room visits, in an urgent care center, in the observation unit or during an inpatient stay do not require notification.

- Compliance with this Protocol is required. Incomplete notification and/or non-notification rates will be tracked

through physician data sharing reports.

- Without completion of the entire notification process described below, a notification number will not be issued. If the imaging study requested for a Customer is performed and the claim is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur.

To see the states in which this Protocol applies, or for the most current listing of CPT codes that require Notification, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Authorization. If additional states are added to the program, we will communicate that information to impacted Physicians/Providers.

Ordering physician/provider

- The Physician/Provider ordering the imaging service is responsible for obtaining a notification number prior to scheduling Advanced Outpatient Imaging Procedures. The process required by this Protocol for ordering Physicians/Providers is as follows:
- Obtain the required notification number by contacting us:
    - Online: UnitedHealthcareOnline.com → Notifications → Radiology Notification & Authorization - Submission & Status
    - Fax: (866) 889-8061
    - Phone: (866) 889-8054

The information listed below may be requested at the time of the notification request:

Customer/procedure information

- Customer's name and Customer's UnitedHealthcare ID number
- Customer's address and telephone number
- Customer's group number
- Customer's date of birth
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The primary diagnosis or "rule out" with the ICD-9-CM (or its successor) code(s)

Physician/provider information

- Ordering Physician's or health care professional's name, TIN/NPI, specialty, address, and telephone number
- Physician/Provider to whom the Customer is being referred, if specified, and the address
- Rendering physician's or health care professional name and TIN/NPI

Clinical information

- The Customer's clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering Physician/Provider believes would be useful in evaluating whether the service ordered meets current evidence-based guidelines, such as prior diagnostic tests and consultation reports.
- If the requested imaging study is consistent with evidence-based clinical guidelines, a notification number will be communicated to the ordering Physician/Provider at the time of the request.

OR

- If the imaging study requested for the Customer is not consistent with evidence-based clinical guidelines, or if further information is needed to assess the request, the ordering Physician/Provider participates in a physician-to-

physician discussion to understand the request, provide additional clinical information, and to consider alternative approaches. Upon completion of the discussion, the ordering Physician/Provider will confirm the procedure ordered and a notification number will be issued. The ordering physician maintains final decision authority.

The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on clinical guidelines. This discussion is not a preauthorization, precertification or medical necessity determination.

- Notification numbers will be communicated to the ordering Physician/Provider when the notification process is completed. They will be communicated by telephone, fax and/or online, consistent with how the request was initiated. To help promote proper payment, this number should be communicated by the ordering Physician/Provider to the rendering Physician/Provider scheduled to perform the advanced Outpatient Imaging Procedure. Please note that the receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that notification was made. Medical coverage/payment authorization is a separate process determined by the Customer's benefit contract and your agreement with us.

Urgent requests

Physician/Provider may request a notification number on an urgent basis if the Physician/Provider determines it to be medically required. We will issue a notification number for urgent requests within 3 hours of our receiving all required information. If the Physician/Provider determines that care must be provided before a notification number can be issued on an urgent basis, the services should be performed and the notification requested retrospectively following the Retrospective Notification process described below.

Retrospective notification

- If an advanced Outpatient Imaging Procedure is required on an urgent basis or notification cannot be obtained because it is outside of UnitedHealthcare's normal business hours, the service may be performed and notification can be provided retrospectively.
- Retrospective notification requests must be made within 2 business days after the service.
- Ordering Physicians/Providers should follow the same notification process outlined above for a standard request.
- Documentation must include an explanation as to why the procedure was required on an urgent basis or why notification could not be obtained during UnitedHealthcare's normal business hours.

Rendering physician/provider

Except as provided in this Protocol, in order to receive payment for covered services rendered, the rendering Physician/Provider must validate with us prior to performing an Advance Outpatient Imaging Procedure that a notification is on file by contacting us as follows:

- Online: UnitedHealthcareOnline.com → Notifications → Radiology Notification & Authorization - Submission & Status
- Phone: (866) 889-8054 (select prompt 2 to check status of a notification request)

If the rendering Physician/Provider determines there is no notification on file, and the ordering Physician/Provider participates in UnitedHealthcare's network, UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to obtain the notification from the ordering Physician/Provider prior to the rendering of services.

If the rendering Physician/Provider determines there is no notification on file, and the ordering Physician/Provider does not participate in UnitedHealthcare's network, or is unwilling to submit notification, the rendering Physician/Provider is required to complete the notification process. If the rendering Physician/Provider does not provide notification for services ordered by a non-participating Physician/Provider, the rendering Physician/Provider's claim will be denied for failure to provide notification and the Customer cannot be billed for the service.

Provision of additional advanced outpatient imaging procedures

If, during the provision of an Advance Outpatient Imaging Procedure, the rendering Physician/Provider determines that additional services should be delivered above and beyond the service(s) for which notification has been obtained, the rendering Physician/Provider should render those service(s) and obtain retrospective notification following the Retrospective Notification process described above.

Products included in the Outpatient Radiology Notification Program

Commercial benefit plans issued and administered by UnitedHealthcare or one of its affiliates, that are subject to this Guide, and for which the physician is required to provide prior notification, are subject to the Radiology Notification Program. In-scope products include such products as Choice, Choice Plus, Choice HMO, Choice Plus HMO, Definity HRA/HSA, Select and Select Plus, Select HMO and Select Plus HMO.

Products/Customers excluded from the Outpatient Radiology Notification Program

Benefit plans issued or administered by Oxford Health Plans, LLC; Oxford Health Insurance, by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC, by M.D. Individual Practice Association, Inc. (M.D. IPA), Optimum Choice, Inc. (Optimum Choice), Benesight, GoldenRule, MAMSI Life and Health Insurance Company (MLH), Neighborhood Health Partnership, UnitedHealthcare Services Company of the River Valley, Inc.*, UnitedHealthcare Plan of the River Valley*, Inc. or UnitedHealthcare Insurance Company of the River Valley*, that are subject to the administrative guide or manual of that affiliate, are excluded. Also excluded are governmental benefit plans for Medicare and Medicaid Customers, and benefit plans for which the Customer (rather than the physician) is required to provide notification, such as Options PPO and UnitedHealthcare Indemnity.

These excluded benefit plans may have separate Radiology Notification or prior-authorization requirements.

Radiology Prior Authorization Program (for Medicare Advantage Customers)

The outpatient Radiology Prior Authorization requirements in this Protocol apply to all participating physicians, health care professionals, facilities and ancillary providers ("Physicians/Providers") that order or render Advance Outpatient Imaging Procedures. Advance Outpatient Imaging Procedures are: Computerized Axial Tomography (CT scan), Magnetic Resonance Image (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Echocardiography, Nuclear Medicine and Nuclear Cardiology.

Please note that only select services within these radiology modalities will require prior authorization. For a complete list of services that require prior authorization, please visit UnitedHealthcareOnline → Clinical Resources → Radiology → Radiology Notification & Authorization.

Prior authorization is required for outpatient advanced imaging services only. Advance imaging services ordered during an emergency room visit in the observation unit, in an urgent care center or during an inpatient stay do not require prior authorization.

Compliance with this Protocol is required. Incomplete prior authorization and/or non-authorization rates will be tracked through physician data sharing reports.

Failure to complete the Radiology Prior Authorization process will result in administrative denial. Claims denied for failure to request prior authorization may not be billed to the Customer. Failure to meet clinical criteria will result in a denial for lack of medical necessity because services that are not medically necessary are not covered under Medicare Advantage plans. Upon issuance of the denial for lack of medical necessity, the Customer and Physician/Provider will receive a denial notice with the appeal process outlined. Physicians /Providers that render advanced imaging services within the scope of the Protocol must confirm that prior authorization has been obtained, or payment for their services may be denied (for both technical and professional components).

To see the states in which this Protocol applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Authorization. If additional states are added to the program, we will communicate that information to impacted Physicians/Providers.

* Except Medicare Advantage benefit plans are subject to this notification requirement and to the prior authorization requirement described below.

Please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Authorization for the latest information on this program.

Ordering physician/provider:

The Physician/Provider ordering the imaging service is responsible for obtaining a prior authorization number prior to scheduling Advanced Outpatient Imaging Procedures. A Physician/Provider may obtain the required prior authorization number by contacting us via:

- Online at UnitedHealthcareOnline.com → Notifications → Radiology Notification & Authorization - Submission & Status, or
- By calling toll-free (866) 889-8054, or
- Faxing to (866) 889-8061. Fax forms can be found on UnitedHealthcareOnline → Clinical Resources → Radiology → Radiology Notification & Authorization → Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Modality-specific Fax Forms

Information required for a Prior Authorization request:

Customer/procedure information

- Customer's ID number
- Customer's group number
- Customer's name
- Customer's date of birth
- Customer's telephone number and address (optional)

Ordering physician/provider information

- Ordering physician/provider's TIN
- Ordering physician/provider's last name
- Ordering physicians/provider's telephone number
- Ordering physician/provider's fax number
- Contact person at the ordering physician/provider's office

Clinical information

- The examination(s) being requested, with the CPT code(s)
- The working diagnosis or "rule out" with the ICD-9 code(s)
- The Customer's symptoms, listed in detail, with severity and duration. Any treatments that have been tried, including dosage and duration for drugs, and dates for other therapies.
- Any other information that the physician believes will help in evaluating the request, including but not limited to prior diagnostic tests, consultation reports, etc.
- Dates of prior imaging studies performed.

Rendering physician/provider information

- Rendering physician/provider's last name, first name
- Rendering physician/provider's address
- Rendering physicians/provider's telephone number
- Rendering physician/provider's fax number

A prior authorization number will be communicated to the ordering Physician/Provider when the prior authorization

process is completed. The number will be communicated by telephone, fax and/or online, consistent with how the request was initiated. To help ensure proper payment, the authorization number should be obtained and communicated by the ordering Physician/Provider to the rendering Physician/Provider scheduled to perform the imaging procedures.

Please note that receipt of an authorization for Medicare services means that the service was medically necessary. It does not guarantee or authorize payment. Payment of covered services is contingent upon the Customer being eligible for services on the date of service, the provider being eligible for payment, any claim processing requirements, and the physician/provider participation agreement with UnitedHealthcare.

The prior authorization number is valid for 45 days. When a prior authorization number is entered for a procedure, UnitedHealthcare will use the day prior authorization was issued as the starting point for the 45 day period in which the examination must be completed. If a procedure is not completed within 45 days, a new prior authorization number must be obtained.

Urgent requests

A Physician/Provider may request a prior authorization number on an "urgent" basis if the Physician/Provider determines it to be medically required.

A prior authorization number will be issued for urgent requests within 3 hours of our receiving all required information.

If the Physician/Provider determines that care must be provided before a prior authorization number can be issued on an urgent basis, the services should be performed and the prior authorization requested retrospectively following the Retrospective Prior Authorization process described below.

Urgent requests should be requested via the phone by calling (866) 889-8054 and selecting the option for Medicare Advantage Customers. The physician/provider must state that the case is clinically urgent and explain the clinical urgency to the clinical decision support representative.

Retrospective prior authorization

If an advanced outpatient imaging procedure is required on an urgent basis or prior authorization cannot be obtained because it is outside of our normal business hours, the service may be performed and authorization requested retrospectively.

Retrospective authorization requests must be made within 2 business days of the service.

The ordering Physician/Provider should follow the same prior authorization process outlined above for a standard request.

Documentation must include an explanation as to why the procedure was required on an urgent basis or could not be prior authorized during UnitedHealthcare's normal business hours.

Rendering Physician/Provider

To receive payment for services rendered, prior to performing the stated Advanced Outpatient Imaging Procedures, the rendering Physician/Provider must validate with UnitedHealthcare that an approved prior authorization is on file by contacting UnitedHealthcare via:

- Online: UnitedHealthcareOnline.com → Notifications → Radiology Notification & Authorization - Submission & Status
- Phone: (866) 889-8054 - select the appropriate Option for Medicare Advantage Customers

If the rendering Physician/Provider determines there is no prior authorization on file, and the ordering Physician/Provider participates in UnitedHealthcare's network, UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to request that the participating ordering Physician/Provider obtain prior authorization prior to the rendering of services.

If the rendering Physician/Provider determines there is no prior authorization on file, and the ordering Physician/Provider does not participate in UnitedHealthcare's network and does not, or is unwilling to submit notification, the rendering Physician/Provider is required to complete the prior authorization process. If the rendering Physician/Provider does

not obtain a prior authorization number for services ordered by a non-participating Physician/Provider, the rendering Physician/Provider's claim will be denied for failure to obtain prior authorization and the Customer cannot be billed for the service.

Note: Non-participating physicians/providers can still submit prior authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054 and selecting the Option for Medicare Advantage Customers.

Provision of additional Advance Outpatient Imaging Procedures

If, during the provision of an Advance Outpatient Imaging Procedure, the rendering Physician/Provider determines that additional services should be delivered above and beyond the service(s) for which prior authorization has been obtained, the rendering Physician/Provider should render those service(s) and obtain retrospective prior authorization following the Retrospective Authorization process described above.

Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, physicians and other health care professionals will not be required to contact the Radiology Prior Authorization program to modify the existing prior authorization record. A complete listing of codes is available at UnitedHealthcareOnline → Clinician Resources → Radiology → Radiology Notification → Reference Materials.

However, for code combinations not listed on the CPT Code Crosswalk Table, the Radiology Prior Authorization protocol provision for additional advanced imaging service will still apply and a modification to the authorization would need to occur for those procedures.

If the procedure that is being performed is for a contiguous body part, then either the ordering or rendering Physician/Provider may modify the original prior authorization by calling (866) 889-8054 and selecting the appropriate Option for Medicare Advantage Customers. If an additional procedure needs to be performed and it is not for a contiguous body part, the ordering Physician/Provider must obtain a new prior authorization number. A test for a different, noncontiguous body part will be considered a new request.

Products included

This program applies to Customers enrolled in benefit plans offered through the SecureHorizons, Evercare, UnitedHealthcare and AARP MedicareComplete brands (who see providers subject to this Guide). These plans can be identified by a "UHC" indicator on the patient health care ID card.

Products/Customers excluded

This program does not apply to benefit plans issued or administered by any legal entities associated with any of the following affiliates: Oxford Health Plans, PacifiCare, Neighborhood Health Partnership, or Sierra. Erickson Advantage Customers are excluded from the Outpatient Radiology Notification program. As a reminder, the Medicare Advantage Customers supported by PacifiCare.com receive a Customer Identification Card containing the "PHS" identifier on the back of the ID card. Customers of these plans are subject to the administrative guide, manual or supplement of that affiliate. The existing requirements regarding notification, authorization and/or precertification for the above listed excluded entities remain in place and the process for authorization will not change. Other excluded plans can be found on the plan inclusion/exclusion grid available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Authorization → Medicare Advantage Radiology Prior Authorization.

Clinical information

Clinical coverage review

- You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, providing pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment. Please refer to the individual services listed in the Advance Notification List for specific, additional required information.
- You must return/respond to calls from the care management team and/or medical director. You must provide complete clinical information as required within 4 hours if request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).
- You can obtain copies of the Coverage Determination Guidelines (CDG) and Medical Policies UnitedHealthcare uses for Commercial products and the UnitedHealthcare Medicare Coverage Summaries Manual used for Medicare products online at UnitedHealthcareOnline.com → Tools & Resources → Policies and Protocols.

In addition and when appropriate, UnitedHealthcare uses Milliman® Care Guidelines®*, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, including acute and sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Concurrent review

- You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR).
- You must return/respond to inquiries from the inpatient care management team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if request is received before 1:00 p.m. local time, or make best efforts to provide requested within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).
- UnitedHealthcare uses Milliman Care Guidelines*, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. You may request a copy of the clinical criteria from your Case Reviewer or by calling the Enhanced Voice Portal at (877) 842-3210.

Laboratory services

Requirement to use participating laboratories

This Protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals except as indicated in the following 2 bullets:

- This Protocol does not apply where the physician bears financial risk for laboratory services.
- This Protocol does not apply to laboratory services provided by physicians in their offices.

We maintain a robust network of more than 1,500 national, regional and local providers of laboratory services. These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the UnitedHealthcare network. Participating laboratories also provide clinical data and related information to support HEDIS reporting, care management, the UnitedHealth Premium Designation program and other clinical quality improvement activities. It is important to note that in many benefit plans, Customers receiving services in out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses.

* For Medicare, if Milliman contradicts CMS guidance, including National Coverage Determinations and Local Coverage Determinations, then UnitedHealthcare will follow CMS guidance.

You are required to refer laboratory services to a participating provider in our network, except as otherwise authorized by us or a Payer. Participating laboratory providers can be found in the UnitedHealthcare directory online at UnitedHealthcareOnline.com. If you need assistance in locating or using a participating laboratory provider, please contact UnitedHealthcare Network Management.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact UnitedHealthcare Network Management in advance to confirm that the specific laboratory test is covered. We will work with you to assure that those covered proven tests are performed, even if that means the use of a non-participating laboratory.

Administrative actions for out-of-network laboratory services referrals

UnitedHealthcare network Physicians have long demonstrated their commitment to affordable health care by making extensive use of participating laboratories. We anticipate that virtually all participating Physicians will be able to easily find a participating laboratory that will meet their needs.

If we identify an ongoing and material practice of referrals to out-of-network laboratory service providers, we will inform the responsible physicians of the issue and remind them that physicians in the UnitedHealthcare network are generally required by contract to refer their patients to other network providers. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with Protocols:

- A change in eligibility for the Practice Rewards programs;
- A decreased fee schedule; or
- Termination of network participation, as provided in your agreement with us.

For state-specific variations of this protocol, please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols

Medicare Advantage Protocol for Institutional Plan

Applicability – This Protocol is only applicable to primary care physicians, nurse practitioners and physicians assistants who participate in the network for Evercare institutional Customers.

Definitions – Capitalized terms used in this protocol but not otherwise defined will have the same meaning as in your participation agreement.

Evercare Institutional Customer: A Medicare beneficiary who permanently resides in a Skilled Nursing Facility and who is enrolled in a Medicare Advantage institutional special needs benefit contract that: (a) exclusively enrolls special needs individuals who are institutionalized (as such term is defined in 42 CFR 422 .2); (b) is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare's affiliates; and (c) is administered by UnitedHealthcare's business unit Evercare, as indicated by a reference to Evercare or Erickson Advantage on the face of the valid identification card of any Evercare Institutional Customer eligible for and enrolled in such Benefit Plan.

Nurse Practitioner: A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

Physician Assistant: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

Primary Care Physician: A professional who meets all of the following criteria: (a) a Doctor of Medicine or a Doctor of Osteopathy or another health care professional as authorized under state law, Skilled Nursing Facility bylaws and the applicable benefit plan to admit or refer patients to Skilled Nursing Facility for covered services; (b) who has been selected by or assigned to an Evercare Institutional Customer to provide and/or coordinate the Evercare Institutional Customer's covered services; (c) whose practice predominantly includes internal medicine, family or general practice;

and (d) who participates in UnitedHealthcare's network.

Primary Care Team: a team comprised of a care manager, a Primary Care Physician, and a Nurse Practitioner or Physician Assistant.

Skilled Nursing Facility: A Medicare-certified nursing facility that (a) provides Skilled Nursing Services and (b) is licensed and operated as required by applicable law.

Evercare Primary Care Physician Protocols

If these Primary Care Physician Protocols differ from or conflict with other protocols in connection with any matter pertaining to Evercare Institutional Customers, these Primary Care Physician Protocols will govern unless statutes and regulations dictate otherwise.

The Primary Care Physician will cooperate with and be bound by these additional protocols:

1. Attend Primary Care Physician orientation session and annual Primary Care Physician meetings thereafter.
2. Conduct face-to-face initial and ongoing assessments of the medical needs of Evercare Institutional Customers, including all assessments mandated by regulatory requirements
3. Deliver health care to Evercare Institutional Customers at their place of residence in collaboration with the Primary Care Team.
4. Family Care Conferences - Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the Evercare Institutional Customer to discuss the Evercare Institutional Customer's condition, care needs, overall plan of care and goals of care, including advance care planning.
5. Primary Care Team collaboration and coordination - Collaborate with other member of the Primary Care Team designated by Evercare and any other treating professionals to provide and arrange for the provision of covered services to Evercare Institutional Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to Evercare Institutional Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled Evercare Institutional Customer reassessment, significant change in plan of care and/or condition.
6. Collaborate with Evercare when a change in the Primary Care Team is necessary.
7. Provide Evercare a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where Evercare Institutional Customers reside.
8. When admitting an Evercare Institutional Customer to a hospital, notify Evercare or Payer immediately if the admission is for an emergency or for observation.

Evercare Nurse Practitioner and Physician Assistant Protocols

If these Nurse Practitioner and Physician Assistant protocols differ from or conflict with other protocols in connection with any matter pertaining to Evercare Institutional Customers, these Nurse Practitioner and Physician Assistant Protocols will govern unless statutes and regulations dictate otherwise.

The Nurse Practitioner and Physician Assistant will cooperate with and be bound by these additional protocols:

1. Attend training and orientation meetings as scheduled by Evercare.
2. Deliver health care to Evercare Institutional Customers at their place of residence in collaboration with a Primary Care Physician, including making joint visits to Evercare Institutional Customers in the facility on a regular basis.
3. Family Care Conferences - Communicate with the Evercare Institutional Customer's responsible parties, family and/or legal guardian on a regular basis. Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the Evercare Institutional Customer to discuss the Evercare Institutional Customer's condition, care needs, overall plan of care and goals of care, including advance care planning.

4. Primary Care Team collaboration and coordination - Collaborate with other members of the Primary Care Team designated by Evercare and any other treating professionals to provide and arrange for the provision of covered services for Evercare Institutional Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to Evercare Institutional Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled Evercare Institutional Customer reassessment, significant change in plan of care and/or condition.
5. Collaborate and communicate with Evercare's designated Director of Health Services to coordinate all inpatient, outpatient and facility care delivered to Evercare Institutional Customers. Forward copies of required documentation to Evercare's office. Work with the Director to develop a network of providers cognizant of the special needs of the frail elderly.
6. Initial Assessment - Conduct a comprehensive initial assessment for all Evercare Institutional Customers within 30 calendar days of enrollment that includes:
    a. History and physical examination, including mini-mental status (MMS) and functional assessment.
    b. Review previous medical records.
    c. Prepare problem list.
    d. Review medications and treatments.
    e. Review lab and x-ray procedures.
    f. Review current therapies (PT, OT, and ST).
    g. Update treatment plan.
    h. Review advance directive documentation including DNR/DNI and use of other life-sustaining techniques.
    i. Contact the family/responsible party within 30 calendar days of enrollment to:
        - Schedule a meeting at the facility, if possible;
        - Obtain further history;
        - Agree on type and frequency of future contacts; and
        - Discuss advance directives.
    j. Perform clinical and quality initiative documentation as directed.
7. Provide care management services to coordinate the full range of covered services outlined in the Evercare Institutional Customer's benefit contract including, but not limited to:
    a. All medically necessary and appropriate facility services.
    b. Outpatient procedures and consultations.
    c. Inpatient care management.
    d. Podiatry, audiology, vision care and mental health care provided in the facility.
8. When admitting an Evercare Institutional Customer to a hospital, notify Evercare or Payer immediately if the admission is for an emergency or for observation.
9. Provide Evercare a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where Evercare Institutional Customers reside.

Specialty pharmacy requirements for procurement of certain specialty medications

Acquisition for administration in the health care setting by physicians and other health care professionals

- This protocol applies to the acquisition, including prescription ordering, clinical coverage review, and purchase, of Synagis®, Xolair®, Botox®, Dysport®, Myobloc®, Xeomin®, Hyalgan®, and Supartz® by physicians and other health care professionals.
- This protocol applies to Commercial Customers only.
- This protocol does not apply when Medicare or another health plan is the primary payer and UnitedHealthcare is the secondary payer.

Requirement to use a participating specialty pharmacy provider for certain medications:

- Synagis (palivizumab)
- Xolair (omalizumab)
- Botox (botulinum toxin type A)
- Dysport (botulinum toxin type A)
- Myobloc (botulinum toxin type B)
- Xeomin (botulinum toxin type A)
- Hyalgan (Sodium hyaluronate and hyaluronan cross-linked preparations. For consistency, these preparations will be referred to as sodium hyaluronate preparations)
- Supartz (sodium hyaluronate)

Note: This protocol does not apply to Euflexxa®, Orthovisc®, Synvisc® and Synvisc-One®. Euflexxa, Orthovisc, Synvisc and Synvisc-One may continue to be purchased and directly billed to UnitedHealthcare. Health care providers may continue to "buy and bill" Euflexxa, Orthovisc, Synvisc and Synvisc-One.

UnitedHealthcare has contracted for the national distribution of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan, and Supartz. Our participating specialty pharmacy provider(s) provide(s) fulfillment and distribution services on a timely basis to meet the needs of our Customer and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy provider(s) also provide(s) reviews consistent with UnitedHealthcare's Drug Policy for these drugs, and work(s) directly with the Clinical Coverage Review unit in UnitedHealthcare's Care Management Center to determine whether treatment is covered. The UnitedHealthcare Drug Policies for these drug preparations are reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics Committee, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support our clinical and quality improvement activities.

You must acquire Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare

Requests for prescriptions of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz should be submitted to the participating specialty pharmacy using the applicable enrollment request forms that are available at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols. The specialty pharmacy will dispense these drugs in compliance with the UnitedHealthcare Drug Policy and the Customer's benefit plan and eligibility, and bill us accordingly. The specialty pharmacy will bill us for the medication. Physicians will only need to bill us the appropriate code for administration of the medication and should not bill us for the medication itself. The specialty pharmacy will advise the Customer of any medication cost share responsibility and arrange for collection of any amount

due prior to dispensing of the medication to the physician office.

For a listing of the participating specialty pharmacy provider(s) by medication, please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols →UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2011 UnitedHealthcare Administrative Guide.

Administrative actions for non-network acquisition of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz

For Customer(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz from a participating specialty pharmacy provider.

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturers by you or any other health care professional without prior approval from us, will result in adjustment of your claim in whole or in part. In addition, you may be subject to other administrative actions as provided in your agreement.

Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

Administration of Xolair in a health care setting

Effective July 2007, the prescribing information for Xolair was updated to include a black box warning on the risk of anaphylaxis that has been reported to occur after as early as the first dose of Xolair but also has occurred beyond 1 year of regularly administered Xolair treatment. The labeling advises that patients should be observed closely for an appropriate period of time after Xolair administration and Xolair should only be administered in a health care setting by physicians or other health care professionals. Physicians and other health care professionals administering Xolair should be prepared to manage anaphylaxis and Customers should be informed of the signs and symptoms of anaphylaxis and instructed to seek immediate medical care should symptoms occur.

UnitedHealthcare's Drug Policy on Xolair includes this updated warning and administration information. The participating specialty pharmacy provider(s) will assist in dissemination of this information as part of the clinical review of Xolair utilization.

Designated specialty pharmacy or home infusion providers for specialty medications

Prohibition of provision of non-contracted services

- This Protocol applies to the provision and billing of specific specialty pharmacy medications covered under a Customer's medical benefit.
- This Protocol prohibits specialty pharmacy or home infusion providers from providing non-contracted services, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, for a therapeutic category and billing us as a non-participating or non-contracted specialty pharmacy or home infusion provider.
- This Protocol does not apply when the administration of specialty medications is conducted in an office setting by a physician or other health care professional, who procures and bills directly to us for the specific specialty medications.
- This Protocol applies to Commercial Customers only.

Requirement of specialty pharmacy and home infusion provider(s) to be a network provider

UnitedHealthcare has contracted with a network of specialty pharmacy and home infusion providers by therapeutic category to distribute specialty medications covered under a Customer's medical benefit. The contracted specialty pharmacy and home infusion providers have been selected by therapeutic category for network inclusion based upon their distribution, contracting, clinical capabilities, and Customer services. This national network provides fulfillment

and distribution of the specialty medications on a timely basis to meet the needs of our Customers and our network. Full program participation requirements are identified in the contracted specialty pharmacy or home infusion provider's participation agreement. Specialty pharmacy and home infusion providers are prohibited, even if they are contracted for other medical benefit medications and services, from providing non-contracted services in a therapeutic category, and billing us as a non-participating or non-contracted provider.

Coverage of self-infused/injectable medications under the pharmacy benefit

- This Protocol applies to the provision and billing of self-infused/injectable medications, such as Hemophilia Factor products, under the pharmacy benefit.

Under most UnitedHealthcare products, self-infused/injectable medications are generally excluded from coverage under the medical benefit, and coverage for a self-infused/injectable medication is provided through the pharmacy rider. This exclusion from the medical benefit does not apply to self-infused/injectable medications necessary to treat diabetes or to medications, which due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified physician or licensed/certified health care professional in an outpatient setting.

Participating physicians, health care professionals, home infusion providers, hemophilia treatment centers or pharmacies fulfilling, distributing, and billing for the provision of self-infused/injectable medications to Customers and subject to the exclusion described above are required to submit claims for reimbursement under the Customer's pharmacy benefit, if those medications are subject to the exclusion described above.

Our claims process

Prompt claims processing

We know that you want your claims to be processed promptly for the covered services you provide to our Customers. We work hard to process your claims timely and accurately. This is what you can do to help us:

1. **Review the Customer's eligibility at UnitedHealthcareOnline.com, using swipe card technology or keying in the Customer's information.**

   You can also check Customer eligibility by phone by calling the Enhanced Voice Portal at (877) 842-3210 or the Customer Care number on the back of the Customer's health care ID card.

   Disclaimer: Eligibility & benefit information provided is not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered and benefit plan terms and conditions. For Medicare plans, reimbursement is also dependent on CMS guidance and claims processing requirements.

2. **Notify us in accordance with the Advance Notification Requirements section** (Please note: Does not apply to members enrolled in M.D. Individual Practice Association, Inc. ("M.D. IPA"), Optimum Choice, Inc. ("Optimum Choice"), MAMSI Life and Health Insurance Company ("MLH") Benefits Plans. For the Radiology Notification/Authorization Program and the Cardiology Notification Program, please see the separate descriptions of the applicable protocols in this Guide.
3. **Prepare complete and accurate claims** (see Complete Claims section).
4. **Submit claims online at UnitedHealthcareOnline.com or use another electronic option.**

   a. **Connectivity Director is a direct connection** for those who can create a claim file in the HIPAA 837 format. This web-based application enables real-time and batch submissions direct to UnitedHealthcare at no cost to you. Connectivity Director provides immediate response back to all transaction submissions (claims, eligibility, and more). Additional information can be found at UnitedHealthcareCD.com, including a comprehensive User Guide and information on how to get started.

   b. **UnitedHealthcare Online All-Payer Gateway™** is a web-based connectivity solution which links UnitedHealthcare Online users to a leading clearinghouse vendor (Ingenix®) that offers multi-payer health

transactions and services at preferred pricing. Using your current UnitedHealthcare Online User ID and password, you can register with Ingenix to submit batch claims to many of your governmental and commercial payers. For more information: UnitedHealthcareOnline.com → Claims and Payments → Electronic Claims Submission → EDI Options.

c. **EDI Gateway and Clearinghouse Connections** – UnitedHealthcare's preferred clearinghouse is Ingenix, but you can use any clearinghouse you prefer to submit claims to UnitedHealthcare. Both participating and non-participating physicians, health care professional, facility and ancillary provider claims are accepted electronically using UnitedHealthcare's payer ID 87726. Other UnitedHealthcare and affiliate payer IDs can be found on UnitedHealthcareOnline.com. at UnitedHealthcareOnline.com → Claims & Payments → Electronic Claims Submissions (EDI)

UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically. Please review your agreement with us and abide by its requirements.

While some claims may require supporting information for initial review, we have reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more. We will request additional information when needed.

5. **Receive Electronic Payments and Statements (EPS)**

If you are enrolled with us for EPS, payments are electronically deposited into one or more checking account(s) which you designate. Take the next step by auto-posting the electronic 835/Electronic Remittance Advice (ERA) that you receive from your clearinghouse, or obtain an ERA free of charge from our website at UnitedHealthcareOnline.com.

Explanations of Benefits (EOBs) that match each daily/weekly consolidated deposit are available on UnitedHealthcareOnline.com, where you can review, store and print hard copies to use for manual posting. EPS is UnitedHealthcare's preferred method for processing payments and statements and results in faster and easier payment to you. If you have not yet enrolled in this standard operating process, start receiving electronic payments and statements now by enrolling online at UnitedHealthcareOnline.com or by contacting us at (866) 842-3278, Option 5. Please note EPS is not available in all markets for our Medicare Advantage plans.

Complete claims

For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services (according to national coding guidelines). It is particularly important to accurately code because a Customer's level of coverage under his or her benefit plan may vary for different services. You must submit a claim for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the Customer at the time of service.

To assist you in understanding how your claims will be paid, UnitedHealthcare's Claim Estimator includes a feature called Professional Claim Bundling Logic which helps you determine allowable bundling logic and other claims processing edits for a variety of CPT (CPT is a registered trademark of the American Medical Association) and HCPCS procedure codes. Note: Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations are not included.

Allow enough time for your claims to process before sending second submissions or tracers, then check the status online at UnitedHealthcareOnline.com. If you do need to submit second submissions or tracers, be sure to submit them electronically no sooner than 45 days after original submission.

Complete claims include the information listed under the Complete Claims Requirements section of this Guide. We may require additional information for particular types of services, or based on particular circumstances or state requirements.

If you have questions about submitting claims to us, please contact Customer care at the phone number listed on the

Customer's health care ID card. For questions specific to electronic submission of claims, please review the information at UnitedHealthcareOnline.com → Claims and Payments → Electronic Claims Submission (EDI). If you need additional information on EDI, contact the EDI Support Line at (800) 842-1109, Option 3.

Learn about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims at UnitedHealthcareOnline.com including: Claim Estimator with bundling logic and Real-Time Adjudication. Training tools and resources including Frequently Asked Questions (FAQs), Quick References, Step-by-Step Help and Tutorials are available by clicking "Help" at the top of any page.

Note: At the time of publication of this Guide, the Claim Estimator is not available for Medicare Advantage benefit plans.

To order 1500 HICF (CMS-1500) and UB-04 (CMS-1450) forms, contact the U.S. Government Printing Office, call (202) 512-0455, or visit their website at cms.hhs.gov/CMSForms.

Complete claims requirements

- Customer's name
- Customer's address
- Customer's gender
- Customer's date of birth (dd/mm/yyyy)
- Customer's relationship to subscriber
- Subscriber's name (enter exactly as it appears on the Customer's health care ID card)
- Subscriber's ID number
- Subscriber's employer group name
- Subscriber's employer group number
- Rendering Physician, Health Care Professional, or Facility Name
- Rendering Physician, Health Care Professional, or Facility Representative's Signature
- Address where service was rendered
- Physician, Health Care Professional, or Facility "remit to" address
- Phone number of Physician, Health Care Professional, or Facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
- Physician's, Health Care Professional's, or Facility's NPI and federal TIN
- Referring physician's name and TIN (if applicable)
- Date of service(s)
- Place of service(s) (for more information see: cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf)
- Number of services (day/units) rendered
- Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate
- Current ICD-9-CM (or its successor) diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
- Charges per service and total charges
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if available
- Retail purchase cost or a cumulative retail rental cost for DME greater than $1,000

- Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPAA 837 Professional electronic form.
- Method of Administration (Self or Assisted) for Hemophilia Claims – the method of administration must be noted and submitted with the claim form with applicable J-CODES and hemophilia factor, in order to ensure accurate reimbursement. Method of administration is either noted as self or assisted.

Additional information needed for a complete UB-04 form

- Date and hour of admission
- Discharge date and hour of discharge
- Customer status-at-discharge code
- Type of bill code (3 digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current four-digit revenue code(s)
- Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current ICD-9-CM (or its successor) procedure codes for inpatient procedures
- Attending physician ID
- Bill all outpatient procedures with the appropriate revenue and CPT or HCPCS codes
- Provide specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic) for outpatient services
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449) submitted on a UB-04
- Submit claims according to any special billing instructions that may be indicated in your agreement with us
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the Customer was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount ($.01 or $1.00) must be reported on all other surgical revenue code lines to assure appropriate adjudication
- Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within 3 calendar days of an inpatient admission and are not related to the admission (effective April 1, 2011)

National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized NPI for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for identification purposes in standard electronic transactions. In addition, based on state specific regulations NPI may be required to be submitted on paper claims. HIPAA defines a covered health care provider as any provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered health care providers must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the HIPAA electronic transaction x12N Implementation Guides.

- To avoid payment delays or denials, we require that a valid Billing NPI, Rendering NPI, and relevant Taxonomy code(s) be submitted on both paper and electronic claims. In addition, we strongly encourage the submission of all other NPIs as defined below.
- It is important that, in addition to the NPI, you continue to submit your TIN.

The NPI information that you report to us now and on all future claims is essential in allowing us to efficiently process claims and to avoid delays or denials.

We will continue to accept NPIs submitted through any of the following methods:

1. UnitedHealthcare Online (UnitedHealthcareOnline.com) To update your NPI and related information online, login to UnitedHealthcareOnline.com. Go to "Practice/Facility Profile" and select your TIN. Click "continue", then select the "View/Update NPI Information" tab.
2. For all UnitedHealthcare business, fax your NPI to the appropriate fax number based on your geographic location/state. The fax form can be found under "Most Visited" and "National Provider Identifier" at UnitedHealthcareOnline.com.
3. Call (877) 842-3210, the Enhanced Voice Portal. Select the "Health Care Professional Services" prompt. State "Demographic changes" and your call will be directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.
4. NPI and NUCC taxonomy indicator(s) are collected as part of credentialing, recredentialing, new provider contracting and recontracting efforts.

How to submit NPI, TIN and taxonomy on a claim

The information below provides the location for NPI, TIN and Taxonomy on paper and electronic claims. See definitions in the UB-04 Data Specifications Manual.

HIPAA 837P (Professional) Claim Transaction	
Primary Identifier	Loop 2010AA, NM109
Pay-To Provider Federal Tax ID	Loop 2010AB, NM109
Referring Physician	Loop 2310A, NM109
Rendering Physician	Loop 2420A, NM109
HIPAA 837I (Institutional) Claim Transaction	
Billing Provider Primary ID	Loop 2010AA, NM109
Billing Provider Taxonomy	Loop 2000A, PRV03
Billing Provider Secondary ID (EIN)	Loop 2010AA, REF02
Attending Physician	Loop 2310A, NM109
Operating Physician	Loop 2310B, NM109
HICF 1500 (08-05) Professional Claim Form	
Referring Provider NPI	Field 1 7b
Rendering Provider NPI	Field 24j
Service Facility Location NPI	Field 32a
Billing Provider NPI	Field 33a
Billing Provider Legacy Identifier	Field 33b
Important: Make sure that your claim software supports the revised 1500 claim form (08-05). Reference the 1500.Reference Instruction Manual at nucc.org for specific details on completing this form.	
UB-04 Paper Institutional Claim Form	
Billing Provider NPI	Locator 56
Billing Provider Taxonomy Code	Locator 81

Attending Provider NPI	Locator 76
Operating Provider NPI	Locator 77
Other Provider NPI	Locator 78-79

Coding, reimbursement, and claims processing requirements for Medicare Advantage benefit plans

Section 1833 of the Social Security Act, prohibits payments to any provider unless the provider has provided sufficient information to determine the "amounts due such provider." To that end, UnitedHealthcare implemented various claims processing edits based on National and Local Coverage Determinations, the Medicare Claims Manual, National Correct Coding Initiative (NCCI), and other applicable guidance from CMS, including but not limited to the Official ICD-9-CM Guidelines for Coding and Reporting. These edits are designed to provide UnitedHealthcare with sufficient information to determine:

- The correct amount to be paid;
- Whether the provider is authorized to perform the service;
- Whether the provider is eligible to receive payment;
- Whether the service is covered, correctly coded, and correctly billed to be eligible for reimbursement;
- Whether the service is provided to an eligible beneficiary; and
- Whether the service was provided in accordance with CMS guidance.

Providers participating in the Medicare Advantage network are required to comply with all CMS guidance regarding coding, claims submission, and reimbursement rules. For example, all participating Medicare providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. In the instance that the "Never Event" has not been reported, we will use any means available to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum (NQF) and adopted by CMS, as a Serious Reportable Adverse Event. To the extent that a provider fails to comply with these requirements, that provider's claim will be denied provider liability. Provider cannot bill the Customer for these charges.

There may be situations where UnitedHealthcare has implemented edits where CMS has issued no specific coding guidance. In these circumstances, UnitedHealthcare has reviewed the available guidance in the Medicare Coverage Center and identified coding edits that most align with the applicable coverage rules.

Hospice

When a Medicare Advantage (MA) Customer elects hospice, CMS pays Medicare Certified Hospice providers for all covered services related to the MA Customer's terminal illness. Claims for hospice services should be billed directly to CMS. For services covered under Medicare Part A and Medicare Part B that are not related to the MA Customer's terminal issue, claims must be billed to the applicable Fiscal Intermediary and Carrier. UnitedHealthcare is not financially responsible for these claims. UnitedHealthcare is financially responsible for any additional or optional supplemental benefits under the Medicare Advantage Customer's benefit plan. Additional and optional supplemental benefits are not covered by Medicare and are not related to the Customer's terminal condition -- i.e. eyeglasses, hearing aids, etc.

Claim submission tips

Estimating treatment costs for Definity HRA and HSA plans

To help facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of UnitedHealthcare's online Claim Estimator. The Claim Estimator tool provides a fast and simple way to obtain your professional claim predeterminations through UnitedHealthcareOnline.com at no additional cost to you. With Claim Estimator, you can receive an estimate on whether a procedure will be covered, at what amount and what the claim payment will be. Claim Estimator allows you to share this information with your patient before treatment.

Claims submission tips for Definity HRA and HSA plans

To promote timely claims turnaround and accurate reimbursement for services you render to patients with Definity HRAs or HSAs, please verify patient eligibility and benefits coverage online at UnitedHealthcareOnline.com → Patient Eligibility & Benefits, or you can call the Customer Service number on the back of your patient's health care ID card.

Special note regarding Definity HRA enrollees: Once logged into the Patient Eligibility section of UnitedHealthcareOnline.com, the "HRA Balance" field will be displayed if the patient is enrolled in any Definity consumer-driven health plan. When there are funds available in an HRA account, the current balance will be displayed. This amount is based on the most recent information available and is subject to change. The actual balance may differ from what is displayed if there are outstanding claims or adjustments that have not yet been submitted or processed. Balances for Definity HSA enrollees are not available through the Patient Eligibility application.

Most Definity plans do not require copayments; therefore, please do not ask your Definity-enrolled patients to make a copayment at the time of service unless it is expressly indicated on their health care ID card.

Submit claims electronically through UnitedHealthcareOnline.com or through your clearinghouse relationship to payer ID 87726. Alternatively, you may submit claims to the address on the back of your patient's health care ID card.

Please wait until after a claim is processed and you receive your EOB before collecting funds from your patient because the patient responsibility may be reimbursable through their HRA account and paid directly to you. The EOB will indicate any remaining patient balance. UnitedHealthcare will not automatically transfer the HSA balance for payment; however, the patient can pay with their HSA debit card or convenience checks linked directly to their account balance.

Consumer account cards and qualified medical expenses

Providers may charge UnitedHealthcare HRA or FSA consumer account cards only for expenses that are "qualified medical expenses" (as defined in Section 213(d) of the Internal Revenue Code) incurred by the cardholder or the cardholder's spouse or dependent. "Qualified medical expenses" are expenses for medical care which provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for the purpose of affecting any structure or function of the body. An expense can be defined as a "qualified medical expense", but may not be covered under an enrollee's benefit plan. Providers may not process charges on the consumer account cards for any expenses that do not qualify as qualified medical expenses, including, but not limited to:

- Cosmetic surgery/procedures (which include procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), including the following:
    - Face lifts
    - Liposuction
    - Hair transplants
    - Hair removal (electrolysis)
    - Breast augmentation or reduction

  Note: Surgery or procedures that are necessary to ameliorate a deformity arising from a congenital abnormality, and reconstructive surgery following a mastectomy for cancer, may be qualified medical expenses.
- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Weight loss programs (note, however, that disease-specific nutritional counseling may be covered)
- Illegal operations or procedures

For updated information regarding qualified medical expenses, please consult the Internal Revenue Service (IRS) website at: irs.gov or call the IRS toll-free telephone number at (800) TAX-FORM; (800) 829-3676.

Pass-through billing/CLIA requirements/reimbursement policy

If you are a physician, practitioner or medical group, you must only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our Customers.

For laboratory services, you will only be reimbursed for the services for which you are certified through the Federal Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our Customers for any laboratory services for which you lack the applicable CLIA certification; however, this requirement does not apply to laboratory services rendered by physicians, practitioners or medical groups in office settings that have been granted "waived" status under CLIA.

Payment of a claim is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact.

Special reporting requirements for certain claim types

Reporting requirements for anesthesia services

- One of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV104 with an "MJ" qualifier in loop 2400 SV103. For CMS-1500 paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H.
- When medically directing residents for anesthesia services, the modifier GC must be reported in conjunction with the AA or QK modifier.
- When reporting obstetrical anesthesia services, use add-on codes 01968 or 01969, as applicable, on the same claim as the primary procedure 01967.
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

Laboratory claim submission requirement

Many UnitedHealthcare benefit plan designs exclude from coverage outpatient diagnostic services that were not ordered by a participating physician. Our benefit plans may also cover diagnostic services differently when a portion of the service (e.g., the draw) occurs in the physician's office, but the analysis is performed by a laboratory provider. In addition, many state laws require that most, if not all, laboratory services are ordered by a licensed physician.

Therefore, all laboratory claims must include the NPI number of the referring physician, in addition to the other elements of a complete claim described in this Guide. Laboratory claims that do not include the identity of the referring physician will be rejected or denied.

This requirement applies to claims for both anatomic and clinical laboratory services. This requirement also applies to claims received from both participating and non-participating laboratories, unless otherwise provided under applicable law. This requirement does not apply to claims for laboratory services provided by physicians in their offices. Please also refer to the *Use of Non-Participating Laboratory Services* section of this Guide.

Assistant surgeons or surgical assistants claim submission requirements

- The practice of directing or using non-participating providers significantly increases the costs of services for our members.
- UnitedHealthcare requires our participating providers to use reasonable commercial efforts to utilize the services of in-network providers, including in-network surgical assistants or assistant surgeons to render services to our members.
- Payment is subject to our payment policies (reimbursement policies).

Submission of claims for services subject to medical claim review

In some instances, a claim may be pended or denied with a request for medical records for medical claim review under an applicable medical or drug policy, to determine whether the service rendered is a covered service, for example, Erythropoietin and/or the applicable reimbursement rate. In these cases, a letter will be sent explaining the additional information that is needed.

To facilitate claim processing and avoid delays due to pended claims, please resubmit only what is requested in our letter. The claim letter will state specific instructions of any required information to resubmit, which may vary for each claim. In addition, the letter may also state that you should not send in a claim or request for reconsideration with the letter and medical notes. Please note, you must also return the claim letter with your additional documents.

For more information about UnitedHealthcare drug and medical policies, please see UnitedHealthcareOnline.com → Most Visited → Policies, Protocols and Administrative Guides → Policies.

For Medicare Advantage benefit plans, if it is determined that you are ineligible for payment even though the service is covered, you will be denied reimbursement for these claims and will be liable for the cost of care. You may not bill your patient for the amount that was denied.

Erythropoietin (For Commercial Customers)

For Erythropoietin (EPO) claims we require the Hematocrit (Hct) level to be submitted in order for us to determine coverage under the Customer's benefit plan. For claims submitted via paper to UnitedHealthcare on a CMS-1500 Form, you must enter the Hematocrit (Hct) level in the shaded area of line 24a in the same row as the J-code. Enter Hct and the lab value (Hctxx). For electronic claims, the Hct level is required in the (837P) Standard Professional Claim Transaction, Loop 2400 – Service line, segment MEA, Data Element MEA03. The MEA segment should be reported as follows:

- MEA01 = qualifier "TR", meaning test results
- MEA02 = qualifier "R2", meaning hematocrit
- MEA03 = hematocrit test result

  Example: MEA*TR*R2*33~

The following J codes require an Hct level on the claim:

- J0881 Darbepoetin alfa (non-ESRD use)
- J0882 Darbepoetin alfa (ESRD on dialysis)
- J0885 Epoetin alfa (non-ESRD use)
- J0886 Epoetin alfa, 1,000 units (for ESRD on Dialysis)
- Q4081 Epoetin alfa (ESRD on dialysis)

For EPO claims submitted on a UB04 claim form, an Hct level is not required.

Additional information is available on-line at UnitedHealthcareOnline.com → Clinician Resource → Cancer – Oncology→ Erythropoietin (EPO) Drug Policy.

KRAS (For Commercial Customers)

We require the submission of a pathology report documenting KRAS gene type in order to determine whether the Customer's benefit plan covers Erbitux® (cetuximab J9055) and Vectibix® (panitumumab J9303) for Customers with colorectal cancer.

Please fax the pathology reports to **(915) 231-1970** using the dedicated fax cover sheet that is located at UnitedHealthcareOnline.com → Clinician Resources → Cancer-Oncology → KRAS Testing.

Additional information regarding KRAS testing and the UnitedHealthcare drug policy is also available at this site.

Overpayments

If you identify a claim for which you were overpaid by us, or if we inform you in writing or electronically of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law), from the date of your identification of the overpayment or our request. We may also apply the overpayment against future claim payments to the extent permitted by your agreement with us and applicable law.

All refunds of overpayments in response to overpayment refund requests received from UnitedHealthcare, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter. Refunds of any credit balances existing on your records should be sent to:

UnitedHealth Group Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0804

Please include appropriate documentation that outlines the overpayment, including Customer's name, health care ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from UnitedHealthcare. If the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund.

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician, health care professional, facility or ancillary provider. In the case of an overpayment, we will implement a claim reconsideration and request a refund within at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you can appeal the determination (see the *Claim Appeals* section of this Guide).

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

1. **Subrogation** — To the extent permitted under applicable law and the applicable benefit plan, we reserve the right to recover benefits paid for a Customer's health care services when a third party causes the Customer's injury or illness.
2. **Coordination of Benefits (COB)** — COB is administered according to the Customer's benefit plan and in accordance with applicable law. We can accept secondary claims electronically. To learn more, go to UnitedHealthcareOnline.com → Claims & Payments → Electronic Claims Submission (EDI), contact your EDI vendor, or call EDI support at (800) 842-1109.

Note: When coordinating benefits with Medicare, all COB Types coordinate up to Medicare's allowed amount when the provider accepts assignment. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary.

3. **Workers' Compensation** — In cases where an illness or injury is employment-related, workers' compensation is primary. If notification is received that the workers' compensation carrier has denied a claim for services rendered to one of our Commercial or Medicare Advantage Customers, the provider should submit the claim to UnitedHealthcare, regardless of whether the case is being disputed. It is also helpful to send us the other carrier's denial statement with the claim.

Retroactive eligibility changes

Eligibility under a benefit contract may change retroactively if:

1. We receive information that an individual is no longer a Customer;
2. The Customer's policy/benefit contract has been terminated;

3. The Customer decides not to purchase continuation coverage; or
4. The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim(s) that is affected by a retroactive eligibility change, a claim reconsideration may be necessary except as otherwise required by state and/or federal law. The reason for the claim reconsideration will be reflected on the EOB or Provider Remittance Advice (PRA). If you are enrolled in Electronic Payment System (EPS), you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from us. If we implement a claim reconsideration and a refund is requested, you will be notified at least 30 days prior to any adjustment, or as provided by applicable law or your agreement with us.

Claim correction/resubmit

If you need to correct and re-submit a claim, submit a new CMS-1500 or UB-04 indicating the correction being made. When correcting or submitting late charges on a CMS-1500, UB-04 or 837 institutional claim, resubmit all original lines and charges as well as the corrected or additional information. When correcting UB-04 or 837 Institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim. Hand-corrected claim re-submissions will not be accepted.

Claim reconsideration and appeals process & resolving disputes

Step 1: Claim Reconsideration

If you believe you were underpaid by us, the first step in addressing your concern is to request a Claim Reconsideration.

- The quickest way to submit a Claim Reconsideration request is directly through UnitedHealthcareOnline.com. Go to UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration. Please identify the specific claims in "paid" or "denied" status which you believe should be adjusted and give a description of the requested adjustment.
- If written documentation, such as proof of timely filing, is needed you must use the Claim Reconsideration Request Form found on UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration → Claim Reconsideration Request Form. The form should be mailed to the claim address on the back of the Customer's health care ID card. In certain states such as Arizona, use of this form is not required, but is strongly encouraged.

If you are submitting a Claim Reconsideration Request Form for a claim which was denied because filing was not timely:

1. Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
2. Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

Note: All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit.

- Alternatively, you can call the Customer care number on the back of the health care ID card to request an adjustment for issues which do not require written documentation.
- If you have issues involving 20 or more paid or denied claims, aggregate these claims on the Claim Project online form and submit the form for research and review. Go to UnitedHealthcareOnline.com → Claims & Payments → Claim Research Project.

Step 2: Claim appeal

If you believe you were underpaid by us, the first step in resolving your concern is to submit a Claim Reconsideration as described above.

If you still do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may submit a formal appeal request to:

UnitedHealthcare Provider Appeals
P.O. Box 30559
Salt Lake City, UT 84130-0575

Your appeal must be submitted to us within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review. Our decision will be rendered based on the materials available at the time of formal appeal review.

If you are appealing a claim that was denied because filing was not timely:

1. Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
2. Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

Note: All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit.

If you are disputing a refund request, please send your letter of appeal to the address noted on the refund request letter. Your appeal must be received within 30 calendar days of the date of the refund request letter, or as required by law or your participation agreement, in order to allow sufficient time for processing the appeal, and to avoid possible offset of the overpayment against future claim payments to you. When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe we have made the refund request in error.

If you disagree with the outcome of any claim appeal, or for any other dispute other than claim appeals, you may pursue dispute resolution as described in the *Resolving Disputes* section below and in your agreement with us.

In the event that a Customer has authorized you to appeal a clinical or coverage determination on the Customer's behalf, such an appeal will follow the process governing Customer appeals as outlined in the Customer's benefit contract or handbook.

Medicare hospital discharge appeal rights protocol

Medicare Advantage Customers have the statutory right to appeal their hospital discharge to a Quality Improvement Organization (QIO) for immediate review.

The QIO notifies the facility and UnitedHealthcare of an appeal.

- When UnitedHealthcare completes the Detailed Notice of Discharge (DNOD), UnitedHealthcare will deliver it to the facility. The facility will deliver the DNOD to the Medicare Advantage Customer, or his or her representative, as soon as possible but no later than 12:00 p.m. local time of the day after the QIO notification of the appeal. The facility will fax a copy of the DNOD to the QIO.
- When the facility completes the DNOD, the facility will deliver the DNOD to the Medicare Advantage Customer, or his or her representative, as soon as possible but no later than 12:00 p.m. local time of the day after the QIO notification of the appeal. The facility will fax a copy of the DNOD to the QIO and UnitedHealthcare.

Resolving disputes – agreement concern or complaint

If you have a concern or a complaint about your relationship with us, send a letter containing the details to the address listed in your agreement with us. A representative will look into your complaint and try to resolve it through an informal discussion. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in your agreement with us.

If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, such as the credentialing, notification, or claim appeal processes described in this Guide, you and we will follow the dispute procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in our agreement.

If we have a concern or complaint about your agreement with us, we'll send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us.

Arbitration proceedings will be held at the location described in your agreement with us or if a location is not specified in your agreement, then at a location as described in the Arbitration counties by location section.

Arbitration counties by location

Unless your agreement with us provides otherwise, the following list contains locations where arbitration proceedings will be held. Locations listed under the state in which you provide care are the locations applicable to you.

Alabama
Jefferson County, AL
Alaska
Anchorage, AK
Arizona
Maricopa County, AZ
Arkansas
Pulaski County, AR
California
Los Angeles County, CA
San Diego County, CA
San Francisco County, CA
Colorado
Arapahoe County, CO
Connecticut
Hartford County, CT
New Haven County, CT
Delaware
Montgomery County, MD
District of Columbia
Montgomery County, MD
Florida
Broward County, FL
Hillsborough County, FL
Orange County, FL
Georgia
Gwinnett County, GA
Hawaii
Honolulu County, Hi
Idaho
Boise, ID
Salt Lake County, UT
Illinois
Cook County, IL
Indiana
Marion County, IN
Iowa
Polk County, IA
Kansas
Johnson County, KS
Kentucky
Fayette County, KY
Louisiana
Jefferson Parish, LA
Maine
Cumberland County, ME
Maryland
Montgomery County, MD
Massachusetts
Hampden County, MA
Suffolk County, MA
Michigan
Kalamazoo County, MI
Oakland County, MI
Minnesota
Hennepin County, MN
Mississippi
Hinds County, MS
Missouri
St. Louis County, MO
Jackson County, MO
Montana
Yellowstone County, MT
Nebraska
Douglas County, NE
Nevada
Clark County, NV
Washoe County, NV
Carson City County, NV
New Hampshire
Merrimack County, NH
Hillsboro County, NH
New Jersey
Essex County, NJ
New Mexico
Bernalillo County, NM
New York
New York County, NY
Onondaga County, NY
North Carolina
Guilford County, NC
North Dakota
Hennepin County, MN
Ohio
Butler County, OH
Cuyahoga County, OH
Franklin County, OH
Oklahoma
Tulsa County, OK
Oregon
Multnomah County, OR
Pennsylvania
Allegheny County, PA
Philadelphia County, PA
Rhode Island
Kent County, RI
South Carolina
Richland County, SC
Tennessee
Davidson County, TN
Texas
Dallas County, TX
Harris County, TX
Travis County, TX
Utah
Salt Lake County, UT
Vermont
Chittenden County, VT
Washington County, VT
Windham County, VT
Virginia
Montgomery County, VA
Washington
King County, WA
West Virginia
Montgomery County, MD
Wisconsin
Milwaukee County, WI
Waukesha County, WI
Wyoming
Laramie County, WY

Compensation

Additional fees for covered services

You may not charge our Customers fees for covered services beyond copayments, coinsurance or deductibles as described in their benefit plans. You may not charge our Customers retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide that are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies. This does not prevent you from charging our commercial Customers nominal fees for missed appointments or completion of camp/school forms. Please note, however, that for Medicare Advantage Customers, CMS does not allow the provider to charge for "missed appointments" unless the provider has previously disclosed that policy to the Customer.

Charging Customers for non-covered services

For commercial and Medicare Advantage Customers, you may seek and collect payment from our Customer for services not covered under the applicable benefit plan, provided you first obtain the Customer's written consent. Such consent must be signed and dated by the Customer prior to rendering the specific service(s) in question. Retain a copy of this consent in the Customer's medical record. In those instances in which you know or have reason to know that the service may not be covered (as described below), the written consent also must: (a) include an estimate of the charges for that service; (b) include a statement of reason for your belief that the service may not be covered; and (c) in the case of a determination by us that planned services are not covered services, include a statement that UnitedHealthcare has determined that the service is not covered and that the Customer, with knowledge of UnitedHealthcare's determination, agrees to be responsible for those charges.

In addition, for Medicare Advantage Customers, a Notice of Denial of Medical Coverage must be provided to the Customer advising the Customer when a service is not covered. In the event we are responsible for issuing the Notice of Denial of Medical Coverage, you should ensure that the Customer has received the Notice prior to providing any requested non-covered service.

You should know or have reason to know that a service may not be covered if:

- We have provided general notice through an article in a newsletter or bulletin, or information provided on UnitedHealthcareOnline.com, including clinical protocols, medical and drug policies, either that we will not cover a particular service or that a particular service will be covered only under certain circumstances not present with the Customer; or
- We have made a determination that planned services are not covered services and have communicated that determination to you on this or a previous occasion.
- For Medicare Advantage benefit plans, CMS has published guidance, through National Coverage Determinations, Local Coverage Determinations, and other CMS guidance, indicating that the service may not be covered in certain circumstances. You are required to review the Medicare Coverage Center.

You must not bill our Customer for non-covered services if you do not comply with this protocol.

If you do not obtain written consent as specified above, the rendering provider must accept full financial liability for the cost of care. General agreements to pay, such as those signed by the Customer at any time (including at admission or upon the initial office visit), are not considered written consent under this protocol.

Customer financial responsibility

Customers are responsible for applicable copayments, deductibles and coinsurance associated with their plans. You should collect copayments at the time of service; however, to determine the exact Customer responsibility related to plan deductibles and coinsurance, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) when billing Customers.

If you prefer to collect payment at time of service, you must make a good faith effort to estimate the Customer's responsibility using the tools we make available, and collect no more than that amount at the time of services. Several tools are available on our website to help you determine Customer and health plan responsibility, including Claim Estimator and HRA Balance viewing through the Eligibility Inquiry function at: UnitedHealthcareOnline.com → Claims & Payments → Claim Estimator (Note: Claim Estimator is not available for Medicare Advantage Customers).

You can also use the claim submission feature on UnitedHealthcareOnline.com while the Customer is still in the office and receive a fully adjudicated claim value showing the plan's responsibility and the Customer's responsibility, based on contracted discounts and plan benefits. This will help promote accurate collections and avoid overpayment or underpayment situations. In the event the Customer pays more than the amount indicated on the medical claim EOB, you are responsible for promptly refunding the difference to the Customer.

For Medicare Advantage Customers, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage Customer who is eligible for both Medicare and Medicaid, or his or her representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance) when the state is responsible for paying such amounts. You will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

Financial incentives

We inform our Customers that treatment decisions are made between physicians and Customers, and coverage decisions on health care services are based on the Customer's benefit plan.

- Our staff, our delegates, and the physicians and other health care professionals making our coverage decisions are not rewarded for issuing non-coverage decisions.
- We and our delegates do not offer incentives to physicians or other health care professionals to encourage underutilization of care or services.

Hospital audit services

We use appropriate nationally recognized billing or coding guidelines, as the criteria for audits performed by our Hospital Audit Services Department. These coding guidelines are produced by the American Association of Medical Audit Specialists, in partnership with CMS www.aamas.org/news/natl-audits-guidelines.html. Audits may occur on a pre-payment or post-payment basis, depending on the circumstances and the terms of your agreement with us.

The following sections, *Hospital Requirements and Access*, *Audit Findings & Exit Conference* and *Post Audit Procedures* are specific to our Standard Hospital Bill Audit (as described in the following paragraph), in accordance with the National Hospital Billing Audit Guidelines UnitedHealthcare may conduct other audits, or make other records requests, in addition to Standard Hospital Bill Audits.

The scope of audit for our Standard Hospital Bill Audit includes review of medical records to substantiate charges billed by the hospital. The process below provides details on handling of inappropriate charges identified during the course of an audit. Generally, a UnitedHealthcare Nurse Reviewer is expected to report his/her written findings to the hospital representative and disallow any inappropriate charges at the conclusion of the audit. Inappropriate charges may include, but are not limited to: an individual charge that appears to have been unbundled from the more general charge in which it is commonly included, or a charge not supported by the medical record. Post-audit claim reconsideration will reconcile any overpayments or underpayments identified as a result of the audit process, in accordance with applicable law and your agreement with us.

Hospital requirements and access

- UnitedHealthcare's Hospital Audit Services Department will notify the hospital of the intent to audit a claim by sending a Communication Form. This Form will be addressed to the hospital CFO, his/her designee, or the hospital auditing representative.

- The hospital will provide one of the following:
    - A copy of the itemized bill to UnitedHealthcare's Hospital Audit Services Department within 30 calendar days of the date requested.
    - A copy of the bill breakdown to UnitedHealthcare's Nurse Reviewer at the time of the audit. (The hospital will notify the UnitedHealthcare Hospital Audit Services Department if a bill breakdown will be provided within 30 calendar days after we notify the hospital of our intent to audit if bill breakdown will be provided.)
- The hospital will cooperate in a timely manner, so the UnitedHealthcare Nurse Reviewer can complete the audit scheduling process within 30 calendar days of the scheduling request.
- If there is a requirement for a valid authorization to release medical information, it is the hospital's responsibility to obtain this release from the Customer, or to waive the requirement if permitted under applicable law. In many cases, such authorizations are signed at the time of admission and may already be on file.
- If there is a hospital-imposed fee to audit the medical record, or a copy fee, said fee will be waived unless specified in the hospital's agreement with us.
- Standard Hospital Bill audits will be conducted at the hospital in cooperation with the hospital representative.
- At the time of the audit, the hospital will provide the UnitedHealthcare Nurse Reviewer with access to the medical record, all applicable department charge sheets and, if requested, any applicable hospital policy and procedures.
- The hospital will give our audit vendors the same level of access as our employee auditors, when those vendors are acting at our direction and on our behalf. Any vendor authorized by us to conduct an audit on our behalf will be bound by our obligations under the hospital's agreement with us. This includes any confidentiality requirements regarding the hospital audit, and compliance with HIPAA requirements and use of Protected Health Information
- The hospital will not impose any time limitation on our right or ability to audit, unless stated in the hospital's agreement with us or permitted by applicable state law.

Audit findings and exit conference

- At the completion of each audit, the UnitedHealthcare Nurse Reviewer will participate in an exit conference with the hospital representative. The purpose of the exit conference is to notify the hospital of our audit findings, including overcharges, undercharges, unbilled charges and disallowed unbundled charges for the claims reviewed. UnitedHealthcare's Nurse Reviewer will provide the hospital representative with a copy of the document findings. If the audit occurs at a location other than the hospital, a copy of the findings will be supplied promptly.
- The document findings will list all discrepancies noted during the course of the audit, including: item, unit cost, number charged, number documented, discrepancy, overcharge, undercharge, unbilled charge or disallowed/ unbundled charge.
- During this conference, the hospital representative will have the opportunity to present any conflicting audit findings. If additionally required by our agreement with us or by applicable state regulation, hospital representative sign-off will be obtained.

Post-audit procedures

- **Refund Remittance** – In the event there is an undisputed overpayment, the hospital will remit the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by law.
- **Disputed Audit Findings** – In the event the hospital wishes to dispute any audit findings, the hospital will submit notification of its intent to dispute the audit findings to UnitedHealthcare's Hospital Audit Services Department within 30 calendar days of receipt of the audit findings. The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items.

- **Dispute Resolution** – UnitedHealthcare's Hospital Audit Services Department will respond to notification of disputed audit findings in writing within 60 calendar days of receipt.
- **Escalated Dispute Resolution** – In the event that the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare's Hospital Audit Services Department as well as our Network Management staff. Escalated dispute resolution will cause suspension of recovery efforts associated with the disputed audit findings for the duration of ongoing discussion between parties.
- **Unresolved Dispute** – Either party may further pursue dispute resolution as outlined in your agreement with us.
- **Offsets** – When a refund request has been issued in connection with a Standard Hospital Bill Audit, we will recoup or offset the identified overpayment, underpayment, and/or disallowed charge amounts after the expiration of 35 calendar days from the date of the refund request provided by UnitedHealthcare's Hospital Audit Services Department, except under the following circumstances: (1) the hospital has remitted the amount due within the 35 calendar day repayment period; or (2) the hospital has provided written notification of its dispute of the audit findings, in accordance with the process outlined above, within the 35 calendar day repayment period.

Medicare Advantage risk adjustment data

The risk adjustment data you submit to us must be accurate and complete.

- Remember that risk adjustment is based on ICD-9-CM (or its successor) diagnosis codes, not CPT codes. Therefore, it is critical for your office to refer to the correct ICD-9-CM (or its successor) coding manual and code accurately, specifically and completely when submitting claims to us.
- Diagnosis codes must be supported by the medical record. Therefore, medical records must be clear, complete and support all conditions coded on claims or encounters you submit.
- Be sure to code all conditions that co-exist at the time of the patient visit and require or affect patient care, treatment or management.
- Never use a diagnosis code for a "probable" or "questionable" diagnosis. Instead, code only to the highest degree of certainty.
- Be sure to distinguish between acute and chronic conditions in the medical record and in coding. Only choose diagnosis code(s) that fully describe the Customer's condition and pertinent history at the time of the visit. Do not code conditions that were previously treated and no longer exist.
- Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a 3-digit code if a 5-digit code more accurately describes the Customer's condition.
- Be sure that the diagnosis code is appropriate for the Customer's gender.
- Be sure to sign chart entries with credentials.
- CMS or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner.

Protocol for Notice of Medicare Non-Coverage (NOMNC)

You must deliver required notice to Customers at least 2 calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the Customer's services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of Customer or Customer's authorized representative, if the Customer is incompetent. The notice uses the standard CMS approved version entitled, "Notice of Medicare Non-coverage" (NOMNC). The text may be found on the CMS website or you may contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text.

Any appeals of such service terminations are called "fast track" appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of business of the day that you are notified by the plan or the QIO if the Customer has requested a fast track appeal.

Reimbursement policies

UnitedHealthcare reimbursement policies are available online at UnitedHealthcareOnline.com → Tools and Resources → Policies and Protocols. Reimbursement policies may be referred to in your agreement with UnitedHealthcare as "payment policies."

Quality Management

Health management program information: Case and Disease Management programs (Commercial Customers)

UnitedHealthcare's approach to Case and Disease Management goes beyond traditional medical coverage and preventive services. We use integrated systems and proprietary software for case and disease management that allows us to identify, stratify, assess and intervene in order to identify gaps in care, educate and coordinate access to services. Using medical, pharmacy and behavioral health claims data, our proprietary predictive model system helps us to identify Customers who are at high risk and direct them to our programs for outreach to facilitate the management of their care. Customers can also be identified at time of hospital discharge, through results from our Health Risk Assessment, referred from our Nurse Triage line, through self-referral and through direct referrals by physicians or other practitioners. Participation in these programs is purely voluntary and Customers are allowed to opt out of a program at any time.

Our outbound call programs, built using evidence-based guidelines, assess high-risk Customers for gaps in care. At the core of these programs is health education as well as a focus on self-care and medication management. During normal business hours we give our Customers easy access to information and resources that focus on education, prevention and reminders. Programs also include medical director peer-to-peer conversations that allow practitioners to discuss gaps in care and best practices

UnitedHealthcare manages over 23 high-risk conditions in our case and disease management programs, where appropriate Customers can be referred to our transplant, kidney, cancer, neonatology and maternity resource services programs and engage with clinical specialists in these complex areas. In addition to the health information and support we provide, we also screen for depression and help ensure those with behavioral health needs are directed to the appropriate behavioral health resource. For support with lifestyle oriented risks, we actively refer Customers to our on-line self-directed behavior modification programs for weight management, nutrition, smoking cessation, exercise, diabetes care, stress management and others. Physicians may refer individuals to any of the Case Management or Disease Management programs by calling the physician toll free service number (877) 842-3210, then selecting the care notification prompt to speak with a representative to initiate a referral to the appropriate program. The person will be assessed to determine the appropriate level of intervention. Customers with coverage through UnitedHealthcare's affiliated health plans can be referred by calling the number on the back of the Customer's health care ID card.

Customers with chronic diseases who are at high-risk can benefit from our High-Risk Case Management and Disease Management programs.

High-Risk Case Management

At the core of High-Risk Case Management is the philosophy of identifying complex, at-risk Customers who can benefit from case management services. We work with Customers and their physicians or other health care professionals to facilitate health care access and help with decisions that can have a dramatic impact on the quality and affordability of their health care. Specifically, our programs are designed to ensure that Customers:

- Receive evidenced-based care
- Have necessary self-care skills
- Have the right equipment and supplies to perform self-care

- Have requisite access to the health care delivery system
- Comply with physician medication regimens

Case managers engage the Customer's physician, whether he/she is a primary care physician or a specialist, to help the Customer receive the right care and the right medication at the right time. Our medical directors are engaged in the process of case review and support the provision of evidence-based care. Our case managers utilize community-based resources to meet the needs of Customers such as home health care agencies, equipment vendors, schools, churches or referrals to financial resources. When appropriate, referrals to other internal programs such as disease management, complex condition management, behavioral health, employee assistance and disability are provided.

Depending on a Customer's needs, Customer engagement in the High-Risk Case Management program can range from a few weeks to an indefinite period of time.

Disease Management Programs

UnitedHealthcare offers population based longitudinal Disease Management Programs that are designed to use multiple sources of information, including but not limited to the Ingenix predictive model, to identify and stratify Customers with these conditions into the appropriate level of intervention. The programs are voluntary and at no cost to the participant. Depending on the Customer's benefit plan program, offerings vary and may include:

- Coronary Artery Disease
- Diabetes
- Heart Failure
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer
- High Risk Pregnancy
- Kidney Disease

The goal of the Disease Management programs is to assist Customers in managing their condition. Each program aims to deliver optimal clinical and financial outcomes by targeting the areas with the greatest potential for impact: the right health care provider, the right medications, the right care and the right lifestyle.

Our programs provide information and resources that Customers need to: understand their condition and its implications, learn how to reduce risk factors, maintain a healthy lifestyle, adhere to physician treatment plans and medication regimens, effectively manage their condition and co-morbidities including depression, and receive the most clinically appropriate, cost-effective and timely diagnostic testing.

For some programs, Customers may receive comprehensive assessments by specialty-trained registered nurses to help determine the appropriate level and frequency of interventions required. For many of our programs, Customers also receive educational mailings, newsletters and tools, such as the HealthLog, to assist them in tracking their physician visits, health status and recommended targets or other screenings.

Physicians are notified when their patients participate in the high-risk program. Physicians with patients in moderate intensity programs may receive information on gaps in care. Customers also receive this information and are encouraged to talk to their physicians about screenings, results and goals of treatment. Participants may also call the 24-hour Nurseline℠ services.

Based on an individualized risk assessment, Customers discharged from the hospital may be enrolled in transitional case management. Based on clinical condition, Customers may also receive an outbound call and a letter reinforcing discharge instruction and follow-up.

Note: Disease and case management programs and services may vary on a location-by-location basis and are subject to

change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas and provider participation may vary. Case and disease management services are for informational and support purposes only.

Case and Disease Management Programs (Medicare Advantage Customers)

We are committed to the health and well-being of older, disabled, or otherwise vulnerable individuals. We stimulate innovation in the management of health and illness across the continuum of care and through a commitment to health and wellness, acute illness, chronic illness, multiple chronic conditions, advanced illness and end-of-life support. Our case and disease management programs are designed to fulfill this vision through comprehensive programs leveraging our technology and clinical expertise through the process of engaging the Customer, their family, and their treatment team.

The process begins with the identification and stratifications of Customers. We use our integrated data systems to analyze medical, pharmaceutical, and behavioral health claims data using our proprietary predictive modeling algorithms to identify Customers based on their health risks. For example, using this process, we may identify a Customer at the time of transition that would benefit from health management. A Customer may also be identified for case or disease management from several other sources as well, such as through the Customer's Health Risk Assessment completed at enrollment, or from other areas of the organization such as Customer Service, Disease Management, Pharmacy, the Nurseline, or Utilization Management including inpatient review and discharge planning. We also encourage and accept Customer self-referral, caregiver referral, or direct referral by our practitioners. Health care practitioners are encouraged to refer their patients to our case and disease management programs by calling toll free (877) 842-3210. Upon receipt of a referral, we assess the Customer's need and triage them to the appropriate level of intervention.

Upon identification, we conduct an outreach and assessment to identify gaps in care, implement Customer and practitioner education as needed, and coordinate access to the services the Customer needs. Early outreach is essential to our model, helping to facilitate improved outcomes for our Customers. Our outreach process includes assessment for potential gaps in Customer knowledge and care, followed by creation of a care plan with structured interventions to facilitate the Customer's access to care. The foundation of this process is the use of nationally recognized, evidence-based medical guidelines. Emphasis is placed on teaching Customer self-care, medication management, access to information and resources, and prevention. A key component of this process is engagement of the Customer's practitioners through medical director peer-to-peer discussions regarding the Customer's case, gaps in care, best practices, and evidence-based medical solutions for the Customer's care plan.

We manage Customers with chronic conditions and/or multiple conditions in a variety of case and disease management programs. These programs allow individuals to be referred within our vast network of specialists for their specific conditions. Our programs include screening for depression and coordination to enable those Customers with behavioral health needs to access the appropriate resources. We also help the Customer to address lifestyle-related health issues through the active referral of the individual to programs for weight management, nutrition, smoking cessation, exercise, diabetes care, stress management and other health conditions. Our programs provide information and resources that Customers need to understand their condition and its implications, how to reduce risk factors, maintain a healthy lifestyle, adhere to physician treatment plans and medication regimens, effectively manage their condition and co-morbidities including depression, and receive the most clinically appropriate, cost-effective and timely diagnostic testing to prevent unplanned transitions.

Individuals with chronic diseases who are at high risk may benefit from the programs listed below. Please note that the availability of programs may vary by product and location.

- High **Risk Care Management Program** – facilitates the identification of high-cost, medically complex, at-risk Customers who can benefit from care management services and for whom we can work to significantly impact the quality of the Customer's heath care.
- **Transitional Case Management Program** – designed to provide a short-term facilitation of the Customer's care in order to assist them in stabilizing their health care needs when they have been recently discharged from the hospital or are at risk for readmission due to co-morbidities, functional status, or social needs.

- **Post Acute Transition Program** – provides care management, concurrent review, and ongoing coordination with the Customer and their facility to manage the Customer's length of stay in a skilled nursing facility.
- **Advanced Illness Program** – a longitudinal care management model combining principles of chronic complex care management and palliative care.

Disease Management Programs

Our population-based disease management programs are designed to provide education and support, promoting compliance and prevention of disease advancement to high risk populations. Our goal is to assist individuals in managing their condition, and objectives include the use of evidence-based medicine to identify gaps in care and to prevent avoidable admissions, slow the progression of the chronic condition, and to improve the Customer's quality of life. Customers are identified through processes such as predictive modeling, inpatient census reports, and through Customer self-referral or practitioner referral. The programs are voluntary and are provided at no cost to the Customer.

After a comprehensive assessment, based on the Customer's acuity, a structured intervention program is implemented which may include mailings and outbound calls to address gaps in care. Interventions aim to provide education on self-management, medication management, access to care, and coordination of appropriate tests and practitioner visits. We provide information and resources to help enrolled Customers understand their condition and its implications, how to reduce risk factors, how to maintain a healthy lifestyle, why they should adhere to treatment plans and medication regimens, how to effectively manage their condition and co-morbidities including depression, and how to access the most clinically appropriate, cost-effective and timely diagnostic testing.

Upon enrollment in these programs, the Customer's primary care practitioner is notified of the enrollment to engage their support in the educational process. Some programs incorporate a Health Log to assist Customers in tracking important measures such as medication adherence, key lab values, self-monitoring results, and recommended preventive care screenings. Customers and their practitioners are encouraged to work together to maintain the Health Login order to facilitate continuity of care. Practitioners are also advised that the program is designed to complement the treatment plan, reinforce instructions the practitioner may have provided, and to offer support for healthy lifestyle choices. The program is not intended to diagnose or treat, and it is not a substitute for the practitioner's professional medical advice.

Disease management staff is available to the Customer any time during normal business hours. Programs offered may include:

- **Coronary Artery Disease** – Includes mailed communications to Customers/providers, high acuity nurse outreach, and a semi-annual newsletter
- **Diabetes** – Includes mailed communications to Customers/providers, high acuity nurse outreach, and a semi-annual newsletter
- **Congestive Heart Failure** - High acuity program focused on education, managing co-morbid conditions, adherence to practitioner and medication plans; includes biometric device, daily weight and symptom check, and monthly follow up on gaps and symptoms
- **End Stage Renal Disease (ESRD)** - High acuity program focused on education, managing co-morbid conditions, and adherence to dialysis treatment; includes telephonic case management with focus on first 6 months of dialysis and then less frequent, low intensity management past 6 months
- **Transplant** - Program to identify and manage transplants from evaluation through post-transplant phase

To get additional information about the above programs, or to refer a patient, please contact us at (877) 842-3210.

Clinical performance assessment

The UnitedHealth Premium® physician designation program uses clinical practice information to assist physicians in their continuous practice improvement and to assist consumers in making more informed and personally appropriate choices for their medical care. The program uses national industry, evidence-based and medical society standards with a transparent methodology and robust data sources to evaluate physicians across 20 specialty areas to advance safe, timely, effective,

efficient, equitable and patient-centered care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific measures for quality and local cost efficiency benchmarks in the same specialty. Individual physicians are evaluated for the Premium program if they are contracted and credentialed with UnitedHealthcare and practice in a specialty and geographic location that are included in the Premium program. Designation results are publicly displayed in online physician directories.

In general, the evaluation of physicians for quality of care compares the observed practice or one physician to the observed practice of UnitedHealthcare national rate among other physicians nationally who are responsible for the same interventions, based on published scientific evidence and national standards applied to administrative data. The evaluation of physicians for cost efficiency compares observed episodic costs to the risk-adjusted costs of their peers in the same specialty and geographical area.

We strongly support transparency in our performance assessment criteria and methods. The criteria supporting our clinical performance assessment programs may be viewed at UnitedHealthcareOnline.com, or you may request a copy by contacting UnitedHealth Premium program advisors at (866) 270-5588. For more information regarding the UnitedHealth Premium physician designation program, go to UnitedHealthcareOnline.com → UnitedHealth Premium, or call our toll-free number at (866) 270-5588. Please note the UnitedHealth Premium physician designation program does not apply to Medicare Advantage benefit plans.

Oncology/Hematology - UnitedHealthcare Cancer Registry

Clinical data collection for breast, colorectal and lung cancer

UnitedHealthcare is committed to improving the quality of oncology care and initiated the UnitedHealthcare Cancer Registry in 2007. This registry includes clinical data such as clinical stage, date of diagnosis and current clinical status. As your UnitedHealthcare patients are identified with breast, colorectal and lung cancer, we will be requesting that you provide this clinical information, unavailable on claims data, to UnitedHealthcare. UnitedHealthcare will contact you prior to faxing a Cancer Status Form for completion. In advance, your time and effort is very much appreciated.

The collection of data shall conform to HIPAA privacy and state confidentiality laws, including prohibitions regarding disclosure of medical information without authorization, except as specified in these laws. Providers should implement appropriate specified safeguards to protect the privacy of a patient's medical information from unauthorized or unlawful access, use, or disclosure.

Why should I submit UnitedHealthcare Cancer Status Forms?

Submitting the UnitedHealthcare Cancer Status Form allows you to contribute clinical staging information to the UnitedHealthcare Cancer Registry. In November 2009, UnitedHealthcare shared the first edition of the Oncology Care Analysis reports with oncologists. These reports combined the clinical information supplied by oncologists and incorporated into our Cancer Registry with UnitedHealthcare claims data. The report compares patient care data to existing National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology for three conditions: breast, colorectal and lung cancer. In the future, we will share with you a physician specific report, for your patients meeting the methodology criteria, in addition to national results.

These reports are intended to supplement your practice, help oncologists understand practice strengths and identify areas for improvement. This data is not used to rank, reward or penalize any oncologist. Overall, the results from our first edition support our mutual belief that oncology care in the United States follows established professional standards. However, we did see some gaps and we hope that the report will assist oncologists in addressing those gaps in care with their patients. For more information regarding this program, go to UnitedHealthcareOnline.com → Clinician Resources → Cancer – Oncology, or contact us at unitedoncology@uhc.com.

Clinical guidelines

We use evidence-based clinical guidelines to develop our quality and health management programs. The following chart lists the clinical guidelines and the websites where the most current version of the guideline can be found.

Topic	Name of guideline	Organization/web address
Acute Myocardial Infarction	2009 Focused Update: A Report of the American College of Cardiology Coronary Intervention (Updating the 2005 Guideline and 2007 Focused 2007 Focused Update) and ACC/AHA/SCAI Guidelines on Percutaneous With ST-Elevation Myocardial Infarction (Updating the 2004 Guideline and 2009 Focused Updates: ACC/AHA Guidelines for the Management of Patients	American College of Cardiology/American Heart Association http://content.onlinejacc.org/cgi/content/full/j.jacc.2009.10.015
	ACC/AHA 2007 Guideline for the Management of Patients with Unstable Angina and Non-ST Elevation Myocardial Infarction	American College of Cardiology/American Heart Association http://content.onlinejacc.org/cgi/content/full/50/7/e1
Asthma	2007 National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma	National Heart, Lung and Blood Institute www.nhlbi.nih.gov/guidelines/asthma/index.htm
Attention Deficit Hyperactivity Disorder (ADHD)	2007 Practice Parameter for the Assessment and Treatment of Children, Adolescents and Adults with Attention Deficit Hyperactivity Disorder.	American Academy of Child and Adolescent Psychiatry http://www.aacap.org/galleries/PracticeParameters/JAACAP_ADHD_2007.pdf
Bipolar Disorder – Children & Adolescent	2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder	American Academy of Child and Adolescent Psychiatry http://www.aacap.org/galleries/PracticeParameters/JAACAP_Bipolar_2007.pdf
Cardiovascular Disease	2006 AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease:	American College of Cardiology/American Heart Association http://content.onlinejacc.org/cgi/content/full/47/10/2130
Cardiovascular Disease	2007 Evidenced-based Guidelines for Cardiovascular Disease Prevention in Women	American College of Cardiology/American Health Association http://www.acc.org/qualityandscience/clinical/pdfs/cvdinwomen.pdf
Cholesterol Management	2004 Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults(Adult Treatment Panel III)	National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/guidelines/cholesterol/index.htm
Chronic Heart Failure	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult	American College of Cardiology http://content.onlinejacc.org/cgi/reprint/j.jacc.2008.11.013v1.pdf
Chronic Obstructive Pulmonary Disease	2009 Global Initiative for Chronic Obstructive Lung Disease	http://www.goldcopd.com
Chronic Stable Angina	2007 Chronic Angina Focused Update of the ACC/AHA 2002 Guidelines for the Management of Patients with Chronic Stable Angina	American College of Cardiology/American Heart Association http://www.acc.org/qualityandscience/clinical/guidelines/stable/stable_clean.pdf Original http://content.onlinejacc.org/cgi/content/full/j.jacc.2007.08.002 Focused update
Depression	Practice Guideline For The Treatment of Patients With Major Depressive Disorder Third Edition	http://www.psych.org/guidelines/mdd2010
Diabetes	Standards of Medical Care in Diabetes–2010 Summary of changes	http://care.diabetesjournals.org/content/33/Supplement_1/S11.extract http://care.diabetesjournals.org/content/33/Supplement_1/S3.full
Hemophilia and von Willebrand Disease	World Federation of Hemophilia 2006 National Heart Lung and Blood Institute - von Willebrand Disease	www.wfh.org http://www.nhlbi.nih.gov/guidelines/vwd/index.htm
Human Immunodeficiency Virus Guideline	HIV Medicine Association of the Infectious Diseases Society of America	HIV guideline – 2009 update http://www.idsociety.org/content.aspx?id=9202#mhiv http://www.journals.uchicago.edu/doi/pdf/10.1086/605292

Topic	Name of guideline	Organization/web address
Hyperbilirubinemia in the Newborn	2004 Management of Hyperbilirubinemia in the Newborn Infant 35 or more weeks of gestation	American Academy of Pediatrics http://aappolicy.aappublications.org/cgi/reprint/pediatrics;114/1/297.pdf
Hypertension	2003 The Seventh Report on the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure	National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf
Preventive Services Guideline Medicare Advantage only)	2010-2011 Guide to Clinical Preventive Services – US Preventive Services Task Force (USPSTF)	Agency for Healthcare Research and Quality http://www.ahrq.gov/clinic/pocketgd.htm
Sickle Cell Anemia	Management of Sickle Cell Anemia, 4th edition National Heart, Lung, and Blood Institute (NHLBI). Revised 2002	http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf
Spinal Stenosis	2006 Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care	North American Spine Society http://www.spine.org/Pages/PracticePolicy/ClinicalCare/ClinicalGuidlines/Default.aspx
Substance Use Disorders, Treatment of Patients Practice Guidelines Second Edition	2006 American Psychiatry Association Guideline Watch (April 2007): Practice Guideline for the Treatment of Patients with Substance Use Disorders	http://www.psychiatryonline.com/pracGuide/pracGuideTopic_5.aspx http://www.psychiatryonline.com/content.aspx?aid=149073

This information is provided to you for general reference and is not intended to address every aspect of a clinical situation that may exist now, or in the future. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual Customers. We hope you will consider this information and use it, when it is appropriate. If you do not have internet access and would like information on how to obtain copies of a guideline, please contact Ellen Murphy Blank National Clinical Excellence Manager, at (954) 447-8818.

Important behavioral health information

References to United Behavioral Health also include our affiliates PacifiCare Behavioral Health and PacifiCare Behavioral Health California.

Screening for depression

United Behavioral Health (UBH) is responsible for managing the behavioral health care benefits for most of our Customers. UBH is committed to supporting primary care physicians in identifying and treating mental health disorders. The U.S. Preventive Services Task Force (USPSTF) recommends screening Customers for depression in primary care. If left untreated, depression can adversely affect Customer quality of life and clinical outcomes. For more information on depression, you and your Customers may access the liveandworkwell.com website of UBH. To refer a patient to a participating UBH clinician for assessment and/or treatment, call UBH at the toll-free number on the back of the Customer's health care ID card.

Depression, Alcohol Abuse & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program

UBH has developed an online Preventive Health Program which offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol abuse/dependence and ADHD. A convenient, reliable and free source of pertinent health information, the Preventive Health Program includes: a dedicated section for physicians and other health care professionals with articles addressing aspects of each condition; information about co-morbid conditions; links to nationally recognized practice guidelines from the American Psychiatric Association; a self-appraisal that you can print, use or refer your patients to; and a listing of support resources for you, your Customers and their families. Physicians and other health care professionals may access the program via UnitedHealthcareOnline.com → Clinician Resources → Patient Safety Resources → Behavioral Health or at liveandworkwell.com/prevention.

The importance of collaboration between primary physicians and behavioral health clinicians

A substantial number of Customers who have serious illnesses also have behavioral health conditions. Approximately 20%

of Customers who have had a heart attack are likely to develop depression within 12 months of the event; likewise greater than 20% of Customers with diabetes also have depression.

It is important to determine if a behavioral health clinician is treating a Customer with these and other illnesses. If so, it is helpful to coordinate care with the behavioral health clinician. Coordination of care takes on greater importance for enrollees with severe and persistent mental health and/or substance abuse problems. This is especially true when medications are prescribed, when there are co-existing medical/psychiatric symptoms and when Customers have been hospitalized for a medical or psychiatric condition.

Communication between clinicians can also maximize the efficiency of diagnosis and treatment, while minimizing the risk of adverse medication interactions for Customers being prescribed psychotropic medication. It can also help reduce the risk of relapse for Customers with substance abuse disorders or psychiatric conditions.

Please discuss with your Customers the benefits of sharing essential clinical information. We encourage you to obtain a signed release from each Customer that allows you to share appropriate treatment information with the Customer's behavioral health clinician.

Psychiatric consults for medical patients

Please contact UBH if you would like to arrange a psychiatric consultation for a Customer in a medical bed, are unclear whether a consultation is warranted, or need assistance with any needed authorization. We can be reached by calling the telephone number on the back of the Customer's health care ID card.

Cooperation with quality improvement activities

All participating physicians and providers must cooperate with all quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and completion or improvement action plans;
- Participation in quality audits, including site visits and medical record standards review, and annual Health-care Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies of such records free of charge during site visits or via mail, secure email, or secure fax.

Imaging accreditation

If you perform outpatient imaging studies and bill on a CMS/HICF-1500 or the electronic equivalent, you must obtain accreditation from one of the accrediting agencies listed below.

- American College of Radiology (ACR) at acr.org
- Intersocietal Commission Accreditation of CT Labs (ICACTL) at icactl.org
- Intersocietal Accreditation Commission (IAC) at intersocietal.org
- Intersocietal Commission Accreditation of Magnetic Resonance Labs (ICAMRL) at icamrl.org
- Intersocietal Commission Accreditation of Echocardiography Labs (ICAEL) at icael.org
- Intersocietal Commission Accreditation of Nuclear Medicine Labs (ICANL) at icanl.org

Accreditation is required for the following procedures: CT scan, MRI, Nuclear Medicine/cardiology, PET scan and Echocardiography, in order to avoid the potential reimbursement reductions described below. This accreditation requirement applies to global and technical service claims. The accreditation process takes approximately 6 to 9 months to complete. This Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards.

Upon notice from us, failure to obtain accreditation will affect your right to be reimbursed for procedures rendered using these modalities. As a result, an administrative claim reimbursement reduction for global and technical service claims, in

part or in whole, will occur.

Upon completion and submission of an accreditation application, you will be placed in a pending accreditation status for the modalities in the application if you are:

1. An existing participating provider adding any of the above modalities and/or expanding to a new site, or
2. A newly participating provider.

The pending status will continue for 12 months from the date of submission, or until you have received a decision on your accreditation application, whichever occurs first. During this pending status, reimbursement reductions based on this Imaging Accreditation Protocol will not be imposed.

Accreditation is obtained by submitting an application and fulfilling accreditation standards.

Additional details regarding this accreditation requirement, including a list of the CPT codes for which accreditation is required, are available on UnitedHealthcareOnline.com → Clinician Resources → Radiology → Imaging Accreditation.

General administrative requirements

Access standards

UnitedHealthcare establishes standards for appointment access and after-hours care to ensure timely access to care for Customers. Performance against these established standards is measured at least annually. UnitedHealthcare's standards are shown in the table below.

Type of service	Standard
Preventive Care	Within 4 weeks
Regular/Routine Care Appointment	Within 14 days
Urgent Care Appointment	Same day
Emergency Care	Immediate
After-Hours Care	24 hours/7 days a week for primary physicians

The guidelines listed above are general UnitedHealthcare guidelines; state regulations may require more stringent standards. Contact your Network Management representative for state-specific regulations.

After-hours care

We ask that you and your practice have a mechanism in place for after-hours access to ensure every Customer calling your office after-hours is provided emergency instructions, whether a line is answered live or by a recording. Callers with an emergency are expected to be told to:

- Hang up and dial 911 or
- Go to the nearest emergency room.

In non-emergent circumstances, we would prefer that you advise callers that are unable to wait until the next business day to:

- Go to an in-network urgent care center,
- Stay on the line to be connected to the physician on call,
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames, or
- Call an alternative phone or pager number to contact you or the physician on call.

Arrange substitute coverage

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with UnitedHealthcare so that services may be covered under the Customer's

in-network benefit. We encourage you to go to UnitedHealthcareOnline.com to find the most current directory of our network physicians and health care professionals.

Delay in Service (Inpatient Services)

Facilities that provide inpatient services must maintain appropriate staff, resources and equipment to provide covered services to our Customers in a timely manner. A Delay in Service is defined as a failure to execute a physician order in a timely manner that results in a longer length of stay. A Delay in Service may result for any of the following reasons:

- Equipment needed to execute a physician's order is not available
- Staff needed to execute a physician's order is not available
- A facility resource needed to execute a physician's order is not available
- Facility does not discharge the Customer as indicated in physician's discharge order

Continuity of Customer care following termination of your participation

If your network participation terminates for any reason, you are required to assist in the transition of our Customer's care to another physician or health care professional who participates in the UnitedHealthcare network. This may include providing service(s) for a reasonable time, at our contracted rate during the continuation period, as further described in your agreement with us. Our Customer Care staff is available to help you and our Customers with the transition. At least 30 calendar days prior to the effective date of your departure from the network, we will send notification to affected Customers. If applicable state law requires earlier notification, we will follow that the state law.

Additional Medicare Advantage requirements

If you participate in the network for our Medicare Advantage products, you are required to comply with the following additional requirements for services you provide to our Medicare Advantage Customers.

- You may not discriminate against Customers in any way based on health status.
- You must allow Customers to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on Customers for influenza vaccine or pneumococcal vaccine.
- You must provide female Customers with direct access to a women's health specialist for routine and preventive health care services.
- You must ensure that Customers have adequate access to covered health services.
- You must ensure that your hours of operation are convenient to Customers and do not discriminate against Customers and that medically necessary services are available to Customers 24 hours a day, 7 days a week. Primary Care Physicians must have backup for absences.
- You may not distribute marketing materials or forms to Customers without CMS approval of the materials or forms.
- You must provide services to Customers in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to inform Customers of health care needs that require follow-up and provide necessary training to Customers in self-care.
- You must document in a prominent part of the Customer's medical record whether the Customer has executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.
- You must ensure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.

- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist Customers in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying Customers of network participation agreement terminations.
- You must comply with our medical policies, quality improvement programs and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators, as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals.

Fraud, waste and abuse prevention & training

If you identify potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond appropriately. Please see the *How to Contact Us* section of this guide for contact information. Please note UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

The Centers for Medicare & Medicaid Services (CMS) require Medicare Advantage Organizations and Part D Plan Sponsors, such as UnitedHealthcare, to communicate and provide annual fraud, waste, and abuse training to all entities they contract with to provide benefits or services in the Medicare Advantage or Part D programs.

In April 2010, CMS revised the training requirements to clarify that first tier downstream and related entities who have met the fraud, waste, and abuse certification requirements through enrollment in the fee-for-service Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider are deemed to have met the training and education requirements for fraud, waste, and abuse.

As a contracted provider for UnitedHealthcare's Medicare Advantage programs, you are considered a first tier or downstream entity and are subject to this CMS requirement. However, if you or your organization do not qualify for the deemed status, training is required annually. It is our responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors. To facilitate that, we will be providing your organization with training materials, which will be made available on UnitedHealthcareOnline.com.

Your organization must administer the training materials to your employees and applicable subcontractors. If your organization has already completed a fraud, waste and abuse training program – either on your own or through another health plan sponsor – and that training meets CMS requirements, UnitedHealthcare will accept documentation of that training. Please maintain records of the training (i.e. sign-in sheets, materials, etc). Documentation of the training may be requested by UnitedHealthcare, CMS, or an agent of CMS to verify the training was completed.

Credentialing and recredentialing

We are dedicated to providing our Customers with access to effective health care and, as such, we periodically review the credentials of participating physicians and other health care professionals in order to maintain and improve the quality of care and services delivered to our Customers. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Center for Medicare and Medicaid Services (CMS) requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we utilize the CAQH Universal Provider DataSource (UPD) for gathering credentialing data for physicians and other health care professionals. The CAQH process is available to physicians and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for recredentialing are instructed on the proper method for accessing the CAQH UPD.

Rights related to the credentialing process

Physicians and other health care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the Enhanced Voice Portal at (877) 842-3210.

While current board certification is not a requirement for network participation, it is a requirement for designation in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application.

Customer rights and responsibilities

We tell our Customers that they have specific rights and responsibilities outlined in the Customer materials for Commercial and Medicare Advantage benefit plans, all of which are intended to help uphold the quality of care and services that they receive from you. A copy of the Customer Rights and Responsibilities can be obtained by contacting your Provider Advocate at (877) 842-3210.

The Customer Rights and Responsibilities Statement is also published each July for Commercial plans and each November for Medicare in the Network Bulletin found here: Unitedhealthcareonline.com → Tools & Resources → News → Network Bulletin.

Inform Customers of advance directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to Customers on state law about advance treatment directives, about Customers' rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform Customers of state laws on advance directives through our Customer's benefit material. We encourage these discussions with our Customers.

Access to records

We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to our Customers within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a Customer grievance/appeal, or a regulatory or accreditation agency requirement. These records must be maintained for 6 years, or longer if required by applicable statutes or regulations. For example, for the Medicare Advantage plans, you must maintain the records for 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.

Medical record standards

In providing care for UnitedHealthcare Customers, you should have signed, written policies to address the following:

1. Maintenance of a single, permanent medical record that is current, detailed, organized and comprehensive for each Customer and is available at each visit. The policy must require that the medical record contain the following information:

- Identifying information of the Customer;
- Identification of all providers participating in the Customer's care and information on services furnished by these providers;
- A problem list, including significant illnesses and medical and psychological conditions;
- Presenting complaints, diagnoses, and treatment plans;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Information on allergies and adverse reactions (or a notation that the patients has no know allergies or history of adverse reactions);
- Information on advance directives; and
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the Customer relevant to the particular treatment.

Date all entries, and identify the author and their credentials when applicable. For records generated by word processing software or electronic medical record software, the documentation should include all authors and their credentials. It should be apparent from the documentation which individual performed a given service. Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The provider must also maintain a copy of the original entry.

1. Protection of Customer records, whether in paper or electronic form, against loss, destruction, tampering or unauthorized use. For electronic medical records, you must establish security safeguards in order to prevent unauthorized access or alteration of records without leaving an audit trail to identify the breach. Such safeguards must be programmed so that they cannot be overridden or turned off.
2. Maintenance of medical records in a confidential manner periodic training to office staff regarding confidentiality processes. Records storage must allow for easy retrieval, be secure and allow access only by authorized personnel.
3. Mechanisms for monitoring and handling missed appointments.

We will perform audits to evaluate your documentation procedures. For more information regarding those audits and our medical record review standards, please visit UnitedHealthcareOnline.com → Clinician Resources → Patient Safety Resources → Medical Record Tools & Templates

Non-discrimination

You will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer of UnitedHealthcare or its affiliates or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any Customers in need of the services you provide.

Provide official notice

You should send notice to us at the address noted in your agreement with us and delivered via the method required, within 10 calendar days of your knowledge of the occurrence of any of the following:

- Material changes to, cancellation or termination of, liability insurance;
- Bankruptcy or insolvency;
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;

- Loss or suspension of your license to practice; or
- Transfer of Customer records to another physician/facility due to relocation or closing of your practice.

Provide timely notice of demographic changes

Physician/health care professional verification outreach

UnitedHealthcare is committed to providing our Customers with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO). Your office may receive a call from a member of our staff asking to verify your data that is currently on file in our provider database. Please be assured that this information is confidential and will be immediately updated in our database.

Proactive notification of changes

We ask that you notify us of changes to the following demographic information 30 calendar days prior to the effective date of the change: TIN changes, address changes, additions or departures of health care providers from your practice, and new service locations.

To change an existing TIN or to add a physician or health care provider

You must include your W-9 form to make a TIN change or to add a physician or other health care provider to your practice. To submit the change, please complete and fax the Physician/provider demographic update fax form and the W-9 form to the appropriate fax number listed on the bottom of the fax form.

The W-9 form and the Physician/provider demographic update fax form are available at UnitedHealthcareOnline.com → Contact Us → Service & Support → Forms.

Changes can also be made by submitting the detailed information about the change, the effective date of the change, and a W-9 on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

To update your practice or facility information

You can make all other updates to your practice information by submitting the change directly through UnitedHealthcareOnline.com by using the Practice/Facility profile function found on the global navigation at the top of any UnitedHealthcareOnline.com page. You can also submit your change by: (a) completing the Physician/provider demographic update fax form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our Enhanced Voice Portal at (877) 842-3210.

Physical Medicine and Rehabilitation Services

Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement only if provided by a physician or therapy provider duly licensed to perform those services as described in the applicable benefit plan. PM&R services rendered by individuals who are not duly licensed to perform those services are not eligible for reimbursement, regardless of whether they are supervised by, or billed by, a physician or licensed therapy provider.

Golden Rule Insurance Company, All Savers, & American Medical Security Supplement

Important information regarding the use of this supplement

The Golden Rule, All Savers & American Medical Security Supplement applies to services provided to Insureds enrolled in Golden Rule, All Savers or American Medical Security benefit plans. For services you render to Golden Rule, All Savers and American Medical Security Insureds, if there is any inconsistency between the rest of this Guide and either this Golden Rule, All Savers & American Medical Security Supplement or the Insured's benefit plan, this Golden Rule, All Savers & American Medical Security Supplement and the Insured's benefit plan will prevail.

You may request a printed copy of this or other Protocols and Payment Policies by contacting the Enhanced Voice Portal at (877) 842-3210.

How to contact us

Golden Rule

Resource	Where to go	What you can do there
Notification	Call the number on the back of the Insured's health care ID card or (800) 999-3404	To notify of hospitalizations exceeding 3 days or transplant services outlined in the *Notification Requirements* section of this Supplement.
Benefits and Eligibility	Call the number on the back of the Insured's health care ID card or (800) 657-8205	To inquire about an Insured's plan benefits or eligibility.
Pharmacy Services (Medco)	GoldenRule.com	To review the Prescription Drug List.
	Call the pharmacy number on the back of the Insured's health care ID card (800) 922-1557	To request a copy of the Prescription Drug List.

All Savers

Resource	Where to go	What you can do there
Notification	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To notify of hospitalizations exceeding 3 days, or 5 days prior to a transplant evaluation and selected medical services outlined in the *Notification Requirements* section of this Supplement.
Benefits and Eligibility	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To inquire about an Insured's plan benefits or eligibility.
Pharmacy Services (Medco)	Call the pharmacy number on the back of the Insured's health care ID card or (800) 922-1557	To request a copy of the Prescription Drug List.

American Medical Security

Resource	Where to go	What you can do there
Notification	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To notify of hospitalizations exceeding 3 days or transplant services outlined in the *Notification Requirements* section of this Supplement.
Benefits and Eligibility	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To inquire about an Insured's plan benefits or eligibility.
Pharmacy Services (Prescription Solutions)	Call the pharmacy number on the back of the Insured's health care ID card or (800) 797-9791	To request a copy of the Prescription Drug List.

Our claims process

We know that you want to be paid promptly for the services you provide. This is what you can do to help promote prompt payment:

1. Notify Golden Rule, All Savers or American Medical Security on or before the 4th day of hospitalizations that are expected to exceed 3 days.

2. Notify Golden Rule, All Savers or American Medical Security as soon as possible of proposed transplant procedures.
3. Prepare a complete and accurate claim form.
4. For Golden Rule Insureds - submit electronic claims using Payor ID # 37602. This is the electronic claims routing number for Golden Rule Insureds. Submit paper claims to the address on the Insured's health care ID card.
5. For All Savers & American Medical Security Insureds - submit electronic claims using Payor ID # 81400. This is the electronic claims routing number for All Savers & American Medical Security Insureds. Submit paper claims to the address on the Insured's health care ID card.

Claim adjustments

If you believe you were underpaid, please call All Savers or American Medical Security at (800) 232-5432 or Golden Rule at (800) 657-8205 and request an adjustment as soon as possible and in accordance with applicable statutes and regulations. If you or our staff identify a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

If you disagree with our determination regarding a claim adjustment, you can appeal the determination (see the *Claims appeals* section in this supplement).

Claims appeals

If you disagree with a claim payment determination, send a letter of appeal to the following address:

Golden Rule Insureds

Golden Rule - Appeals Department,
7440 Woodland Drive
Indianapolis, IN 46278

Your appeal must be submitted to Golden Rule within 12 months from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise.

All Savers & American Medical Security Insureds

American Medical Security – Appeals Review
P.O. Box 13597
Green Bay, WI 54307-3597

Your appeal must be submitted to All Savers or American Medical Security within 180 days from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise.

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your participation agreement.

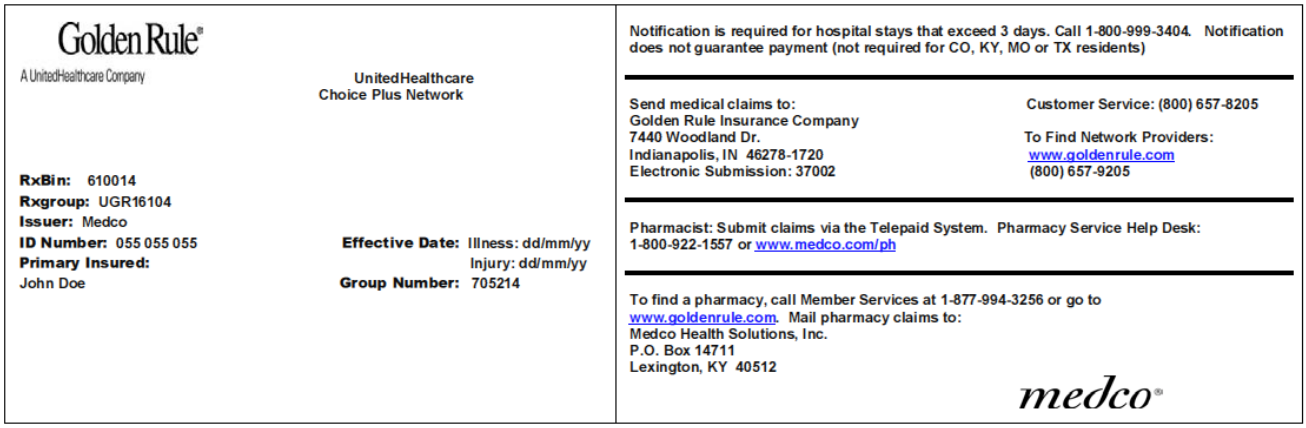
Insured's health care ID card

Golden Rule, All Savers and American Medical Security Insureds receive a health care ID card containing information that helps you submit claims accurately and completely. Information will vary in appearance or location on the card. However, cards display essentially the same information (e.g., claims address, copayment information, and telephone numbers).

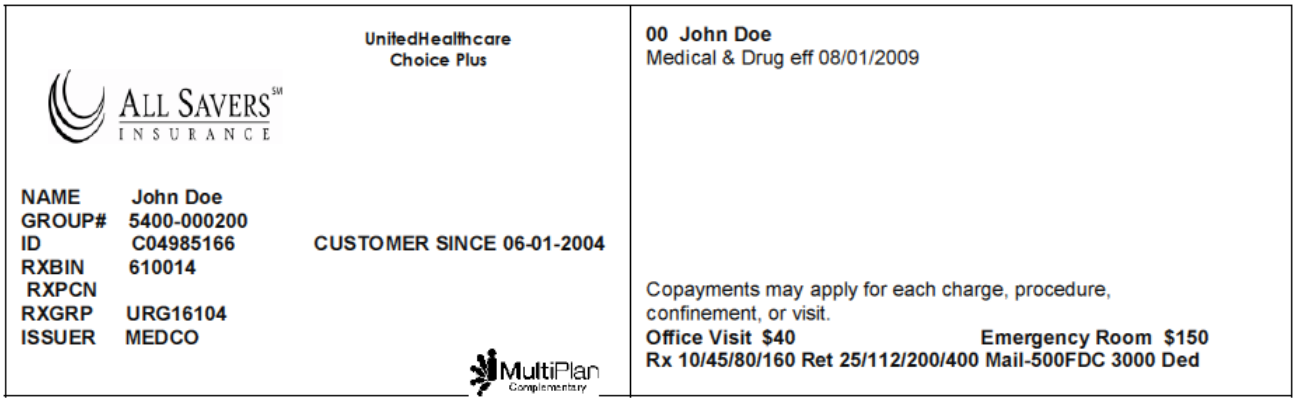
Be sure to check the Insured's health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use All Savers & American Medical Security electronic Payor ID # 81400 or Golden Rule electronic Payor ID # 37602.

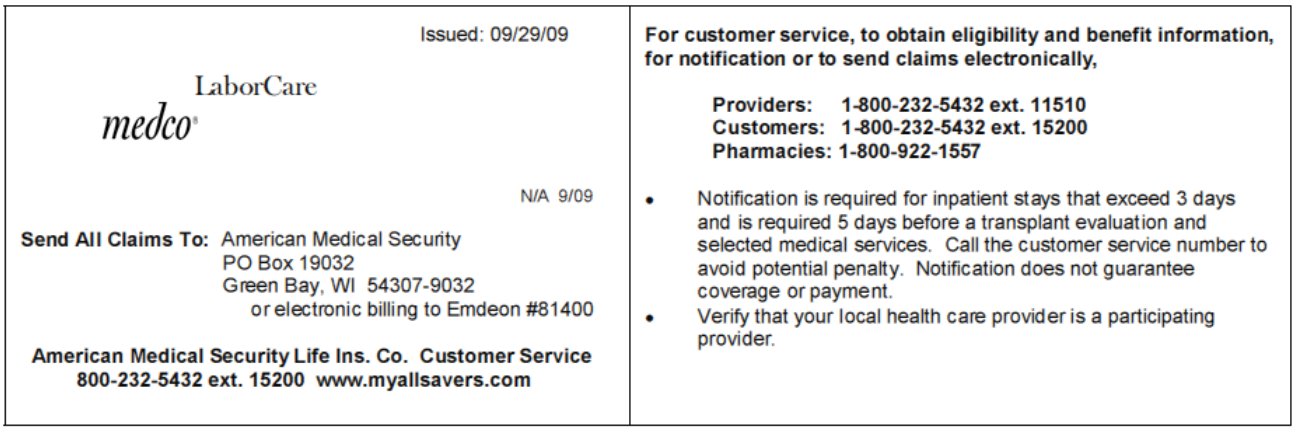
Health care ID cards

Golden Rule sample ID card



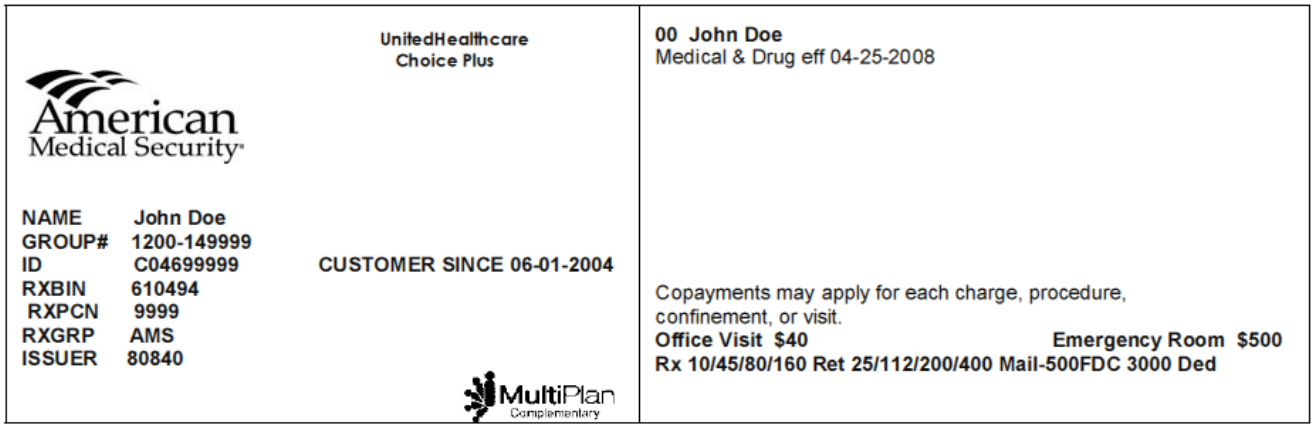
All Savers sample ID card



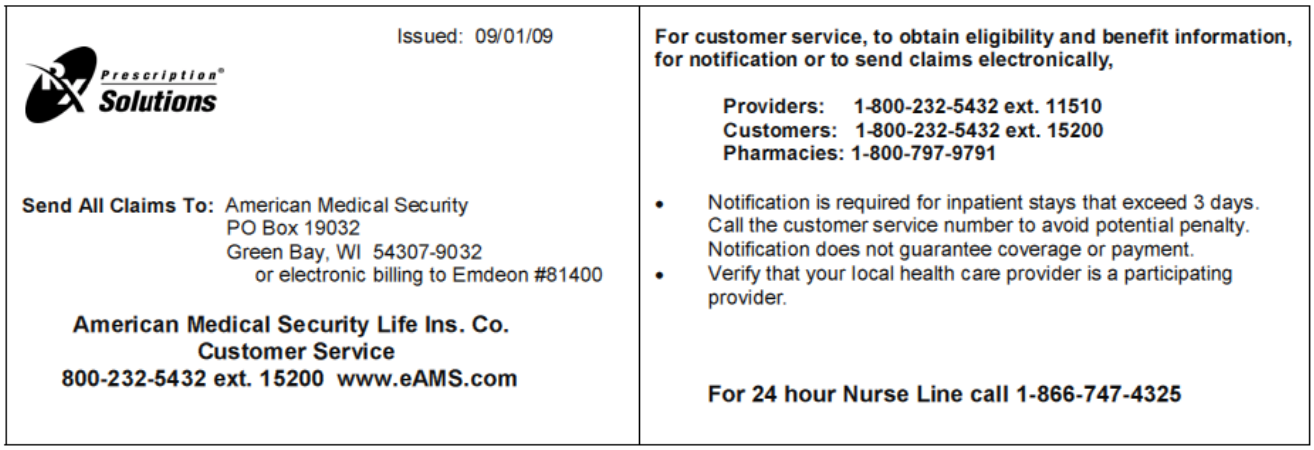


American Medical Security sample ID card

Front



Back



Notification requirements

Notification, in order to be effective, must contain all necessary information including, but not limited to, Insured's name, Insured's health care ID number, hospital name, hospital TIN, primary diagnosis description, anticipated dates of service, type of service and volume of service when applicable. In addition, such notifications must be made to the appropriate phone number listed on the Insured's health care ID card.

Notify American Medical Security or Golden Rule at the number listed on the member's health care ID card for any inpatient facility admission that will exceed 3 days and for proposed transplant services.

Notify Golden Rule and American Medical Security prior to:

Procedures and services	Explanation
Inpatient facility admissions	Inpatient admissions expected to exceed 3 days including: Acute hospitalizations (includes long term acute care), rehabilitation facilities, and skilled nursing facilities (includes sub-acute and hospice) that will exceed 3 days. Notify on or before 4th inpatient day.
Transplant services	Proposed transplant services including evaluations.

Notify All Savers prior to:

Procedures and services	Explanation
Inpatient facility admissions	Inpatient admissions expected to exceed 3 days including: Acute hospitalizations (includes long term acute care), rehabilitation facilities, and skilled nursing facilities (includes sub acute and hospice) that will exceed 3 days. Notify on or before 4th inpatient day.
Transplant services	5 business days prior to pre- transplant evaluations.
Clinical Trials	5 business days prior to beginning a clinical trial.

Notice to Texas providers

For Verification of Benefits for Golden Rule Insureds, please call (800) 395-0923.

For Verification of Benefits for All Savers and American Medical Security Insureds, please call (800) 232-5432.

Golden Rule, All Savers and American Medical Security use Milliman Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, including acute and sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, Golden Rule, All Savers and American Medical Security may also use the medical policies available online at UnitedHealthcareOnline.com → Tools & Resources → Policies and Protocols.

Notification does not guarantee coverage or payment (unless mandated by applicable law). The Insured's eligibility for coverage is determined by the health benefit plan. For benefit or coverage information, please contact the insurer at the telephone number on the back of the Insured's health care ID card.

Important information regarding diabetes

Michigan has a law requiring insurers to provide coverage for certain expenses to treat diabetes. The law also requires insurers to establish and provide to Insureds and participating providers a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines published by the ADA.

The program for participating providers must emphasize best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. You can find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations for 2010 at care.diabetesjournals.org.

To use the Quick Search in the Diabetes Care site, enter the article name in the Keyword(s) box: Standards of Medical Care in Diabetes 2010 and enter Year: 2010; Vol: 33; Pages: S11-S61.

Subscription information for the American Diabetes Journals is available on the website or by calling (800) 232-3472, select option 1, 8:30 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday. You may view journal articles without a subscription online at the website listed above.

Leased Network Supplement

(May apply to providers in HI, ID, KY, ME, MI, MN, ND, SD, USVI, WI; reference your agreement for applicability)

Important information regarding the use of this supplement

UnitedHealthcare's Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the "Guide") is supplemented by this Leased Network Supplement (the "leased Supplement") for physicians, health care professionals, facilities and ancillary providers who participate with UnitedHealthcare through a leased network accessed by UnitedHealthcare in an area where UnitedHealthcare does not have a direct network.

Physicians, health care professionals, facilities and ancillary providers participating in UnitedHeathcare's network through a leased network are subject to both the Guide and the leased Supplement in their respective entireties. However, in the event of any inconsistency between the Guide and this leased Supplement, the leased Supplement will prevail for providers participating in a leased network arrangement.

Leased supplement

Any reference in the Guide to a physician's, health care professional's, facility's, or ancillary provider's "agreement with us" are to be considered simply an "agreement" for purposes of this leased Supplement and refer to your participation agreement with the entity operating the leased network (your "Master Contract Holder").

Several items that appear in the Guide are covered by your agreement with your Master Contract Holder, not the provisions stated in the Guide. Any reference to updating demographic information, submitting National Provider Identification information, credentialing or recredentialing processes and appeal guidelines should follow the processes as indicated in your agreement with your Master Contract Holder.

Mid-Atlantic Regional Supplement

(May apply to providers in DE, DC, MD, NC, PA, VA, WV; reference your agreement for applicability)

Important information regarding the use of this supplement

This Mid-Atlantic Regional Supplement applies to services provided to members enrolled in M.D. Individual Practice Association, Inc. ("M.D. IPA"), Optimum Choice, Inc. ("Optimum Choice") or any benefit plan serviced or administered by OneNet PPO, LLC ("OneNet") (collectively "MAHP members"). In the event of any inconsistency between the Guide and this Mid-Atlantic Regional Supplement, the Mid-Atlantic Regional Supplement and all Protocols and Payment Policies found on UnitedHealthcare Online will apply.

Product summary

This table provides information about M.D. IPA, Optimum Choice and MAMSI Life and Health Insurance Company (MLH) products for the Mid-Atlantic region.

Attributes	M.D. IPA and Optimum Choice	M.D. IPA Preferred and Optimum Choice Preferred	MAMSI Life and Health Insurance Company Products
How do members access physicians and health care professionals?	Members' care must be arranged or coordinated by their Primary Care Physician, except network OB/GYN and routine eye refraction care.	In-network benefits: Members' care must be arranged or coordinated by their Primary Care Physician, except network OB/GYN and routine eye refraction care. Out-of-network benefits: Members' care is not required to be arranged or coordinated by their Primary Care Physician.	Members may choose to access any UnitedHealthcare Choice Plus network physician and health care professional. MAMSI Life and Health insurance company members may have out-of-network benefits.
Does a Primary Care Physician have to make a referral to a specialist?	Yes, except for visits to a network OB/GYN and routine eye refraction care.	In-network benefits: Yes, except for visits to a network OB/GYN and routine eye refraction care. Out-of-network benefits: No referral needed.	No, a referral is not needed.
Is the treating physician required to provide notification for some procedures?	N/A	N/A	Yes, please see the *Notification Requirements* section of this Guide for all Choice Products.

OneNet PPO

OneNet PPO, LLC (OneNet) maintains a large network of physicians, health care practitioners and facilities offering medical, behavioral health and workers' compensation services in the Mid-Atlantic region.

OneNet terminology

- A "OneNet Customer", also called a "Participant", is a person authorized by OneNet to access OneNet participating physicians, health care practitioners, hospitals or facilities under the terms of the physician, health care practitioner, hospital or facility's agreement.
- A "OneNet Payer" is a person or entity that has an obligation to pay for services rendered to a OneNet Customer by a OneNet participating physician, health care practitioner, hospital or facility accessed by a OneNet Customer. OneNet Payers may utilize the services of a Third Party Administrator (TPA) or other entity to provide administrative services, including verifying eligibility and adjudicating and issuing claims payments on behalf of OneNet Payers. References in the physician, health care practitioner, hospital or facility agreement to "participating entity," "Payer," or "Payor" also apply to OneNet Payers.
- The term "OneNet Client" is used to refer to OneNet Payers and any entity that provides administrative services to a OneNet Payer (e.g. a TPA).

OneNet Clients accessing the OneNet network include:

- Insurance carriers
- TPA
- Union health and welfare funds
- Workers' compensation administrators
- And others

OneNet offers a variety of services to assist OneNet Clients in managing health care services. The OneNet Network is constantly growing as more physicians, health care practitioners, and facilities are contracted each year to give OneNet Customers access to quality health care from a large network throughout our service area.

Due to the nature of the OneNet network, OneNet operational and administrative guidelines can differ from M.D. IPA, Optimum Choice and MLH. For information and instruction on OneNet's policies and processes with regard to services provided to OneNet Customers, please refer to the OneNet Physician, Health Care Practitioner, Hospital and Facility Manual ("OneNet Manual").

The OneNet Manual provides information on ID cards for OneNet Customers, how and where to submit claims for OneNet Customers, Utilization Management guidelines and who to contact if you have a question about OneNet claim pricing.

A copy of the OneNet Manual is available from:

- UnitedHealthcareOnline.com → Administrative Guides Section;
- Your network representative;
- Professional Services Department at (800) 342-6141 (Mon. - Fri., 8:00 a.m. to 8:00 p.m.);
- OneNetPPO.com → Health Care Professionals Section

The OneNet Manual is reviewed and revised on an annual basis.

You may also use onenetppo.com to check claim pricing status and find other participating physicians, health care practitioners, hospitals and facilities in the OneNet network. A secure login specific to the OneNet website is available by calling our Professional Services Department at (800) 342-6141, and is required to view claim pricing sheets and access other proprietary OneNet information. Your username and login for onenetppo.com is different from your UnitedHealthcareOnline.com username and password.

OneNet PPO does not adjudicate or pay claims. OneNet claim pricing sheets reflect the amount of a claim after the

application of the participating physician, health care practitioners, hospital or facility's OneNet contracted rate. Pricing sheets have not been adjudicated by the OneNet Payer, and may include billed charges that the OneNet Payer may determine to be the OneNet Customer's responsibility. These charges will be detailed on the OneNet Payer's explanation of benefits or workers compensation remittance advice. Questions about claims payment should be directed to the OneNet Client at the telephone number listed on the OneNet Customer's ID card, or at the contact information listed on the OneNet Client's explanation of benefits.

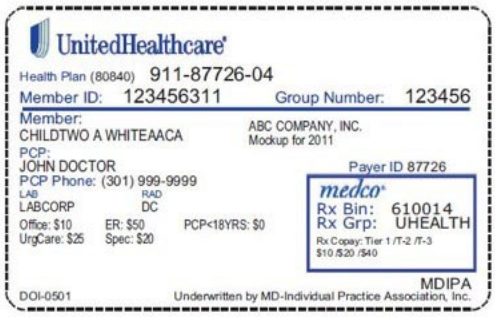
If you need assistance or have any questions about OneNet PPO, please call our Professional Services Department at (800) 342-6141.

Health care ID cards

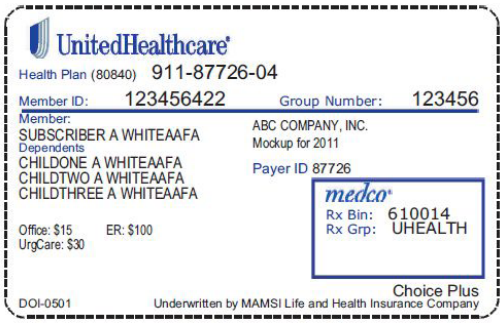
Customers enrolled in M.D. IPA and Optimum Choice benefit plans will present with a plastic health care ID card. For all Optimum Choice and M.D. IPA benefit plans, the health care ID card will display the UnitedHealthcare logo at the top left-hand corner and will indicate "Optimum Choice, Inc" or M.D. IPA benefit name in the lower right corner of the card. In addition, all M.D. IPA and Optimum Choice Customers enrolled in benefit plans will have a member number without an asterisk. Be sure to use the telephone numbers and addresses noted on these health care ID cards.

Effective 1/1/2011, M.D. IPA and Optimum Choice will no longer use paper cards. If a Customer presents with a paper card, please request an updated plastic card from the Customer and verify the Customer's benefits on UnitedHealthcareOnline.com.

Sample health care ID cards for M.D. IPA and Optimum Choice benefit plans*:



Sample card:



* Please note that some members may have ID cards which indicate M.D. IPA Preferred or Optimum Choice Preferred benefits.

How to contact us

Resource	Where to go	What you can do there
Online services	Use UnitedHealthcareOnline.com for Customers enrolled in M.D. IPA and Optimum Choice benefit plans.	• Register for UnitedHealthcare Online • Review a Customer's eligibility or benefits • Electronic Referral System › Submit notifications (for MLH product using the Choice Plus network) › Check status of or update existing notifications (for MHL product using the Choice Plus network) › View claim pre-determination and bundling logic using claim Estimator › Submit claims on-line CMS 1500 only › Check claims status › Request a claims adjustment or a reconsideration when attachments are not needed. › Submit a claim research project for 20 or more claims using the claim Research Project online form › Update facility/practice data (except TIN) › Review the physician, health care professional, and facility directory › Look up your fee schedule, 10 codes at a time with the exception of capitated arrangements › Review/print a current copy of this Supplement › View UnitedHealthcare MAHP protocols and policies › View current and past issues of our Network Bulletin › Access and review clinical program information and patient safety resources
Electronic Claim Submission (EDI Support Line)	(800) 842-1109 To obtain information on HIPAA Transactions & code sets go to hipaa.uhc.com → Uniprise → CompanionDocument Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com → Claims & Payments → Electronic Claims Submissions, under EDI Tools & Resources	• Obtain information on submitting claims electronically • Use our payer ID 87726
Voice Activated Telephone System	For Customers enrolled in M.D. IPA and Optimum Choice and MAMSI Life and Health Insurance/Choice Plus Network benefit plans, call (877) 842-3210.	To inquire about a Customer's eligibility or benefits, check claim status, check to see if a procedure requires precertification, verify copayment information and more. You will need your provider and TINs.

Claims process

Please refer to the section "Prompt Claims Process" in the main section of this Guide for detailed information about our claims process. The section applies to those products governed under the Mid-Atlantic region. For claims purposes, providers should follow the guidelines outlined in the Mid-Atlantic Supplement.

All claims should be submitted electronically to Payer Number 87726. For claims appeals for OCI and M.D. IPA, please send your letter of appeal to the address on the back of the member's health care ID card or follow the instructions on the Provider Remittance Advice (PRA) or on the correspondence received from UnitedHealthcare. Instructions are also available on the UnitedHealthcareOnline.com under the Eligibility and Benefits Section.

For OneNet PPO claims, please refer to the OneNet PPO, LCC Physician, Health care Practitioner, Hospital and Facility Manual.

Health services

This section applies to M.D. IPA and Optimum Choice members and includes both the OCI/M.D. IPA products.

To notify us of the procedures and services outlined in the Preauthorization, Precertification section of this Mid-Atlantic Regional Supplement, call:

- Inpatient Preauthorization or Precertification call (800) 962-2174;
- Outpatient Preauthorization or Precertification call (800) 738-1837;
- The Health Services staff is available during the business hours of 8:30 a.m. to 5:30 a.m. EST.

Inpatient admission notification

All participating facilities are required to notify the health plan of an admission of a member within 24 hours or the next business day following a weekend or federal holiday, whichever comes first. The health plan will initiate a case review upon receipt of your notification. If notification is not provided in a timely manner, the health plan may still review the case and request additional medical information. If you fail to notify in a timely manner, the health plan may retroactively deny 1 or more days based upon its case review. If the patient is eligible for benefits on the date of admission, the health plan will not deny the first day of the admission if the treating provider previously received preauthorization of the scheduled admission. Provide admission notification to Health Services via phone at (800) 962-2174 or via fax at (800) 352-0049.

In the event a member receiving outpatient services needs an inpatient admission, the facility must notify the health plan as noted above. Emergency room services that culminate in a covered admission will be payable as part of the inpatient stay provided the facility has notified the health plan of the admission as noted above.

Delay in service

Facilities that provide inpatient services must maintain appropriate staff, resources and equipment to ensure that covered services are provided to members in a timely manner. A Clinical Delay in Service is defined as any delay in medical decision-making, test, procedure, transfer, or discharge that is not caused by the clinical condition of the member. Services should be scheduled the same day as the physician's order. However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day, unless emergent treatment was required. A delay may result in sanction of the facility by the health plan and non-reimbursement for the delay day(s), if permissible under State law.

A Delay in Service will be assessed for any of the following reasons:

- A failure to execute a physician order in a timely manner that will result in a longer length of stay
- Equipment needed to execute a physician's order is not available
- Staff needed to execute a physician's order is not available
- A facility resource needed to execute a physician's order is not available
- Facility does not discharge the patient on the day the physician's discharge order is written

Concurrent review

Review is conducted on-site at the facility or telephonically for each day of the stay using nationally-accepted criteria. You must cooperate with all requests for information, documents or discussions from the health plan for purposes of concurrent review including, but not limited to, clinical information on patient status and discharge planning. When criteria are not met, the case is referred to a medical director for determination. The health plan will deny payment for hospital days that do not have a documented need for acute care services. The health plan requires that physicians' progress notes be charted for each day of the stay. Failure to document will result in denial of payment to the hospital and the physician.

Hospital post-discharge review

When a member has been discharged before notification to the health plan can occur or before information is available for certification of all the days, a post-discharge review will be conducted. A health plan representative will request the member's records from the Medical Records Department or via a telephonic review and review each non-certified day for appropriateness and acuity. Inpatient Days that do not meet acuity criteria will be referred to a medical director for determination and may be retrospectively denied. Delays in service or days that do not meet criteria for intensity of service may be denied for payment.

Hospital-to-hospital transfers

The hospital must notify the health plan of a request for hospital-to-hospital transfer. In general, transfers are approved when there is a service available at the receiving hospital that is not available at the sending hospital; the member would receive a medically appropriate change in the level of care at the receiving facility; or the receiving facility is in-network

and has appropriate services for the member. If any of the conditions above are not met, coverage for the transfer will be denied. Services at the receiving hospital would be approved if medical necessity criteria for admission were met at the receiving hospital, and there was no delay in providing services at the receiving hospital.

Preauthorization and precertification requirements

Preauthorization is required for all non-emergency, planned admissions for all M.D. IPA and Optimum Choice members.

Services requiring preauthorization or precertification

Certain services require preauthorization or precertification for M.D. IPA, and Optimum Choice members. These requirements vary for M.D. IPA and Optimum Choice members.

Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon member eligibility, benefits and applicable state law.

Procedures requiring precertification

The following list applies to M.D. IPA, Optimum Choice, M.D. IPA Preferred and Optimum Choice Preferred Customers.

Be sure to submit your request at least 2 business days prior to the provision of services. Also, please keep in mind some procedures and services listed here may not be covered under the member's benefit plan. If you have any questions, please contact the Professional Services Department at the number on the back of the member's health care ID card.

Procedures and services requiring preauthorization or precertification: written request		
• Acupuncture[1]	• Experimental Services/New Technologies	• Pulmonary Rehabilitation
• Angiomas/hemangioma (with pictures)	• General Anesthesia for Dental Procedures	• Radiology
• Biofeedback	• Gynecomastia Surgery (with pictures/ indicated testing)	• Capsule Endoscopy › CTs- Brain, Chest, Musculoskeletal, Colonography › MRI of Brain, Heart, Chest, Musculoskeletal › PET Scans (non-cancer diagnoses) › Virtual procedures
• Blepharoplasty (with pictures/indicated testing)	• Home Care	
• Breast implant Removal	• Hysterectomy (inpatient or outpatient)	
• Breast Reconstruction (non-cancer diagnoses only)	• Infertility Services[1]	
• Chiropractic Services[1] (if not subject to a maximum dollar amount)	• Joint Replacement (hip, knee, ankle, shoulder)	• Reduction Mammoplasty (with pictures/ indicated testing)
• Clinical Trials	• Laminectomy/Fusion (inpatient or outpatient)	• Rhinoplasty/Septo-rhinoplasty (with pictures/indicated testing)
• Cochlear implants	• Occupational Therapy (after 8 visits)	
• Congenital Anomaly Repair (with pictures, indicated testing)	• Morbid Obesity (surgery/procedures)	• Sclerotherapy (with pictures/indicated testing)
• Cosmetic and Reconstructive Surgery (with pictures and other documentation as required) –including but not limited to vein procedures, nasal surgery, orthognathic surgery)	• Pelvic Laparoscopy	• Sleep Apnea (oral appliances and surgery)
	• Physical Therapy[2] (after 8 visits)	• Speech Therapy[2] (after 8 visits)
	• Prosthetic devices except for prosthetic contact lenses	• Temporomandibular Disorder (TMD) or related Myofascial Pain Dysfunction Syndrome (MPD) Treatment
• Dental procedures in a facility	• Psychiatric Therapies including, but not limited to:[3] › Electroconvulsive Therapy (ECT) › Psychological Testing (including Psychological and Neuropsychological testing and extended developmental testing) › Substance Abuse Treatment (Outpatient, detoxification, intensive Outpatient Services, Routine Outpatient Services with a Primary Diagnosis of Substance Abuse)	• Transplants (and evaluations)
• Dental services (except removal of cysts/ tumors and fracture care)		• Vagal Nerve Stimulator
• Discectomy/Fusion (inpatient or outpatient)		
• Durable Medical Equipment (for a complete list of DME items which do not require preauthorization, visit UnitedHealthcareOnline.com)[4]		
• Elective inpatient procedures and admissions must be preauthorized. Precertification also required for: › Joint replacement (hip, knee, ankle, shoulder) › Morbid Obesity surgery		

Procedures and services requiring preauthorization or precertification: telephone or written request
• Ambulance Services (non-emergency) • Cardiac Angioplasty (inpatient or outpatient) • Coronary Artery Bypass Graft • Dialysis (precertification by PCP) • Psychiatric Therapies (preauthorization/precertifications can be made by telephone) › Inpatient Services (non-emergency) › Psychiatric Partial Hospitalization and Intensive Outpatient Treatment › Substance Abuse Treatment (Inpatient Rehabilitation, Partial Hospitalization) • Radiation Therapy **Exception Requests** All exceptions to the health plan's policies and procedures must be preauthorized. The most common, but not a comprehensive list of, exception requests are: • Immunizations (outside the scope of health plan guidelines) • Lower level ambulatory surgery procedures rendered in Montgomery and Prince George's counties in Maryland in a hospital • Referral of a HMO member out of network to a non-participating physician, health care practitioner or facility.
Exception Requests All exceptions to the health plan's policies and procedures must be preauthorized. The most common, but not a comprehensive list of, exception requests are: • Immunizations (outside the scope of health plan guidelines) • Lower level ambulatory surgery procedures rendered in Montgomery and Prince George's counties in Maryland in a hospital (Medicare levels one to four) • Refer a Customer out-of-network to a non-participating physician, health care practitioner or facility

1 Initial preauthorization/precertification request must be submitted by the member's Primary Care Physician (PCP).

2 All Occupational Therapy, Physical Therapy and Speech Therapy services in an outpatient setting.

3 Precertify these services through the Behavioral Health Department.

4. For DME, please go to UnitedHealthcareOnline.com → Tools and Resources → Policies and Protocols, click on more in the Protocols sections, and select Mid-Atlantic Protocols, Durable Medical Equipment.

Laboratory and radiology services

M.D. IPA and Optimum Choice Customers must use the outpatient commercial medical laboratory noted on their health care ID card for outpatient commercial medical laboratory services. Depending on where the Customer lives, the health care ID will note:

- LAB=LABCORP (Laboratory Corporation of America)
- LAB=PAR (may use any participating outpatient commercial medical laboratory. Our online directory of healthcare professions is available at UnitedHealthcareOnline.com).

M.D. IPA and Optimum Choice Customers must use the radiology vendor noted on the health care ID card. Depending on the Customer's Primary Care providers office location the health care ID card will note:

- RAD=PAR (may use any office based participating provider)
- RAD=County (this card will list the name of a county, i.e., "Montgomery". Specific vendors are available for referral based on the county listed on the Customer ID card. A complete list of County specific radiology vendor may be found at UnitedHealthcareOnline.com → Tools and Resources → Protocols → Mid Atlantic Protocols. (Note: The Lab and Radiology Protocols are currently under revision.)

Obtaining select, provider-administered injectable medications

Following are key drugs requiring use of a particular vendor and preauthorization:

- Botox (Botulinum Toxin Type A)
- Myobloc (Botulinum Toxin Type B)
- Dysport (Botulinum Toxin Type A)
- Xeomin (Botulinum Toxin Type A)

- Synagis (palivizumab)
- Xolair (omalizumab)
- Supartz (Sodium Hyaluronate)
- Hyalgan(Sodium Hyaluronate)
- Following are key drugs requiring pre-authorization:
- Amevieve (alfacept)
- Erythrocyte Stimulating Agents
- Hyaluronic Acid injection Agents
- Orencia (abatacept)
- Remicade (inflizimab)
- Rituxan (rituximab)
- Tysabri (natalizumab)

Note: The list above is valid as of June 1, 2010. Medications not included above may require inclusion of a specific diagnosis for payment. For current listings, go to UnitedHealthcareOnline.com or call contact numbers below.

Information on our medical evidence-based policies is available at: UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Policies → Medical & Drug Policies and Coverage Determination Guidelines. For additional policies and information, call (800) 355-8530.

Specialty pharmaceutical vendor information available at: UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols, or call (866) 429-8177. All drugs are appropriate for office-based administration. (Call to request an exception to office-based administration.)

Requests for preauthorization must be faxed to (800) 787-5325. Include clinical notes and name of specialty pharmacy vendor. For questions, call (800) 355-8530.

If authorized, Pharmacy Services will provide a written authorization number and coverage dates. This authorization should be submitted to the specialty pharmacy vendor along with the medication order. UnitedHealthcare will call provider's office within 3 business days if conditions are not met for providing the drug.

Procurement of Synagis

M.D. IPA and Optimum Choice, Inc. contract with a specific specialty pharmacy for dispensing of Synagis for members that have already obtained prior authorization from the Health Plan Synagis treatment requires prior authorization which can be obtained by faxing the RSV Enrollment form or equivalent information to Pharmacy Services at (800) 787-5325. You may contact Pharmacy Services with questions about the prior authorization process at (800) 355-8530. You can obtain the RSV fax enrollment form at UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources. You can reach PharmaCare/CVS Caremark at (800) 952-4065.

If you have questions about obtaining Synagis, please call the UnitedHealthcare Specialty Referral Pharmacy Line at (866) 429-8177.

Procurement of Botox/Myobloc/Dysport/Xeomin, Xolair Supartz and Hyalgan

M.D. IPA and Optimum Choice, Inc. contract with a specific specialty pharmacy for dispensing of Botox/Myobloc/Dysport/Xeomin,Xolair, Supartz and Hyalgan for members that have already obtained prior authorization from the Health Plan.

Botox/Myobloc/Dysport/Xeomin, Xolair, Supartz and Hyalgan require prior authorization which can be obtained by faxing the prior authorization request form or equivalent information to Pharmacy Services at (800) 787-5325. You may contact Pharmacy Services with questions about the prior authorization process at (800) 355-8530. You can obtain

the prior authorization request forms at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols.

If you have questions about obtaining Botox/Myobloc/Dysport/Xeomin,Xolair, Supartz or Hyalgan, please call the UnitedHealthcare Specialty Referral Pharmacy Line at (866) 429-8177.

Claim appeals and reconsideration processes

Clinical appeals

To appeal an adverse decision (a decision by us not to preauthorize or precertify a service or procedure or a denial of payment because the service was not medically necessary or appropriate), you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter will provide you with the filing deadlines and the address to use to submit the appeal. In the event a member designates a healthcare professional to appeal the decision on the member's behalf a copy of the member's written consent is required and must be submitted with the appeal.

Requests for additional information

In the event your claim is received and we need additional information to complete the processing of your claim you will receive notice via a letter. The letter will provide you with the filing deadlines and the address to use to submit the additional information as well as the information necessary to finalize your claim. A copy of the letter should be returned with the requested documentation.

How to request reconsideration of an administrative denial

Requests for Reconsideration for M.D. IPA and Optimum Choice should be submitted with a letter and any attached documentation to the address listed on the on the back of the Customer's health care ID card. The subject line of the letter should state "Reconsideration".

Note: This is not an appeal and should not be stated as such in the letter.

Member rights and responsibilities

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

These rights and responsibilities can be found on:

- myuhc.com for M.D. IPA and Optimum Choice members enrolled in updated benefit plans; or
- UnitedHealthcareOnline.com for MAMSI Life and Health Insurance Company members as well as M.D. IPA and Optimum Choice members enrolled in benefit plans.

Primary care reimbursement

Primary Care Physicians are reimbursed for medical services through capitation or fee-for-service payments. Primary Care Physicians are required to submit encounter data for services covered under capitation.

Capitation

On the fifth of the month, the Health Plan sends each Primary Care Physician (PCP) a fixed payment referred to as capitation. The PCP receives a separate capitation payment for members of M.D. IPA and Optimum Choice. A PCP's monthly capitation is based on the number, age and sex of the members on the PCP's panel. PCP's receive capitation payments monthly regardless of whether or not panel members are seen during a particular month. The different Capitation Reports furnished to the PCP are described below:

ECap Report Name	ECap Report Purpose
7030-A01: Capitation Analysis Summary – Provider Medical Group Report	High-level capitation information by current and retro periods for each provider.
7010-A01: Capitation Paid RECap – Provider Medical Group Report – Summary	A contract-level report that summarizes the capitation paid by current and retro periods. The three sections of the report show amounts: 1. Standard services 2. Supplemental benefits and capitated adjustments 3. Non-capitated adjustments and withholds
7010-A02: Capitation Paid RECap – Primary Care Provider Report - Detail	A PCP-level report that summarizes the capitation paid by current and retro periods. The three sections of the report show amounts for: 1. Standard services 2. Supplemental benefits and capitated adjustments 3. Non-capitated adjustments and withholds
7210-A01: Capitation Details – Primary Care Provider Report for Standard Services-(PMG)	Detailed member capitation information for each current member within a PCP.
7240-A01: Member Changes Capitation Details – Primary Care Provider Report for Standard Services-(PMG)	Detailed member retroactive change information on added, changed and terminated members. The three sections of the report show information: 1. Member adds 2. Member demographic changes 3. Member terms
7290-A01: Capitation Adjustment Details – Primary Care Provider Report-(PMG)	Capitation adjustment details for member and provider-level manual adjustments. The two sections of the report show information: 1. Current period 2. Retro period

Fee-for-Service

Certain procedures are reimbursed fee-for-service in addition to capitation. Refer to UnitedHealthcareOnline →Tools and Resources → Policies & Protocols → Protocols for Mid Atlantic Region for more information. (Note: A "Fee-for-Service" Protocol is currently being developed.)

For more detailed information on capitation reports, retroactive reconciliation and member transfers, please refer to UnitedHealthcareOnline →Tools and Resources → Policies & Protocols → Protocols for Mid Atlantic Region.

Note: Protocols are currently being developed to support this information..

Neighborhood Health Partnership Supplement

Important information regarding the use of this supplement

This Neighborhood Health Partnership ("NHP") Supplement applies to services provided to members enrolled in NHP Benefit Plans. In the event of any inconsistency between the Guide and this NHP Supplement, the NHP Supplement and all Protocols and Payment Policies found on myNHP.com will prevail for NHP members.

How to contact us

Resource	Where to go	What you can do there
Website Support	e-Services (800) 276-8237 (for Website technical issues, password resets, etc.)	• Get technical support for website issues
Electronic Data Interchange (EDI) Support	(866) 509-1593	• Obtain information on submitting claims electronically
Customer Care	(877) 972-8845 For the hearing impaired, please call 711 and ask for the number above Customer Service hours: 8 a.m. – 6 p.m. EST	• Check member eligibility information • Verify benefits • Check claim(s) status
Claims	Electronic Payer ID 95123 or 96107 P.O. Box 5210 Kingston, NY 12402	• Submit claims and claims attachments
Appeals	P.O. Box 025680 Miami, FL 33102-5680 Fax: (305) 715-2110	• Reconsiderations and appeals
Automated Referral Line (IVR System)	(877) 972-8845	• Request referrals to specialist • Obtain status of referrals • Obtain Eligibility & Benefits
Utilization Management	(800) 550-5568 Fax: (800) 731-2515 (800) 729-1574	• Request prior authorizations and Precertifications • Obtain status of prior authorizations and Precertifications • Request urgent pre-service appeals on behalf of a member
United Behavioral Health (UBH)	(800) 817-4705	• Obtain information about Behavioral Care Services
Foot and Ankle Network	(305) 558-0444 Fax: (305) 557-3810	• Obtain information about Podiatry Services
ACN Group, Inc (OptumHealth)	(800) 873-4575 Fax: (763) 595-3333	• Physical Therapy (PT) • Occupational Therapy (OT) • Speech Therapy (ST)
Advocate Health Alliance	(305) 728-2747 (866) 374-4326 (outside Miami-Dade) Fax: (305) 728-1425 (800) 722-4148	• Home Health Care Services • Durable Medical Equipment
Quality Managed Healthcare, Inc.	(954) 236-3143 Fax: (954) 236-3254	• Obtain information about Chiropractic Services
Medco Health Solutions, Inc.	Rx Prior Auth (800)753-2851 Specialty Rx Referral (866)429-8177 Prescription Solutions (888) 739-5820 Fax: (800) 837-0959	• Obtain information about Pharmacy Services • Obtain Rx Authorization
CareCore National (CCN)	(866) 242-9546 Fax: (866) 466-6964	• Obtain information about Precertification Services

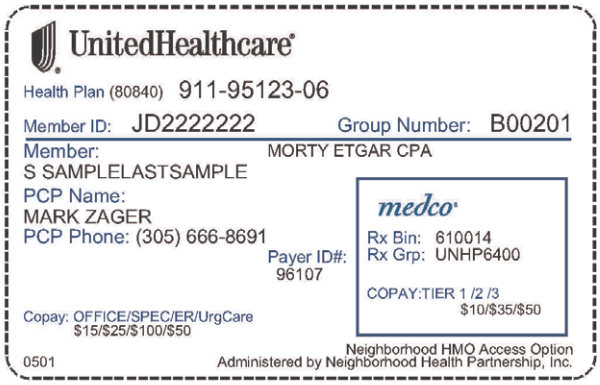
Health care ID cards

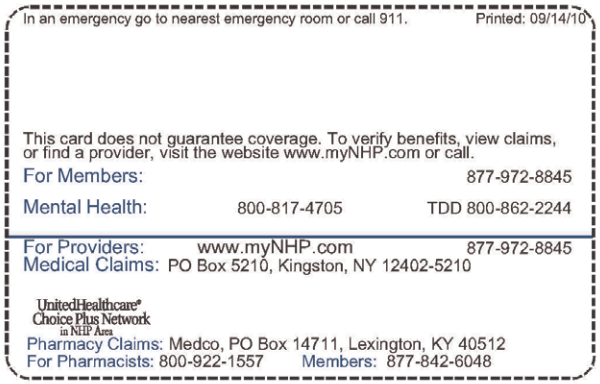
The member's NHP ID card will indicate what type of plan the member has and all applicable co-pays. Below is a sample of the NHP Plan ID card.

Sample ID cards

Old look

New look





Definitions

Agency means the State of Florida Agency for Health Care Administration.

Authorization means referrals and Precertifications.

CMS means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

OIR means the State of Florida Office of Insurance Regulation, Department of Financial Services.

Emergency medical condition and emergency services (collectively Emergency)

Emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: serious jeopardy to the health of the individual (or an unborn child); serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, Emergency Medical Condition is present when there is inadequate time to effect safe transfer to another hospital prior to delivery; when a transfer may pose a threat to the health and safety of the patient or fetus; or when there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency services means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists, and if it does, the care, treatment or surgery for a Covered Service by a physician which is necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

Medically necessary means those Covered Services that, as determined by the NHP Medical Director or designee, a) are appropriate and necessary to diagnose or treat the member's symptoms or medical condition; (b) are provided for the diagnosis or direct care of the member's medical condition; c) are not primarily for the convenience of the member, the member's family, attending or consulting physician; (d) are in accordance with standards of good medical practice within the community where Provider is located; (e) are approved for use in he manner prescribed by a Participating Provider by the appropriate medical body or board for the diagnosis or treatment of the member's medical condition; and (f) are the most appropriate, efficient and economical medical supply, service or level of care which can be safely provided for the member's medical condition.

Participating provider means a provider of health care goods and services including, without limitation, physicians, hospitals, skilled nursing facilities, home health agencies, and ancillary service providers, which has contracted with NHP to provide certain services to members in accordance with the terms of an agreement between the provider and NHP.

Practitioner means a medical doctor, osteopathic doctor, podiatrist, chiropractor, nurse practitioner, and other individual health care providers.

Primary care (including Primary Care Services) means comprehensive and readily accessible Medically Necessary Covered Services including, without limitation, health promotion and maintenance, treatment of illness and injury, early detection of disease and referral to Participating Providers when appropriate, coordinated by the Primary Care Physician with other Participating Providers.

Primary Care Physician or **PCP** means a physician, duly credentialed in accordance with the policies and procedures of NHP, who has agreed to provide Primary Care Services to members in accordance with the terms of an agreement with NHP.

Specialist physician means a Participating Provider, licensed to practice medicine in the State of Florida, duly credentialed in accordance with the policies and procedures of NHP, who has agreed to provide Medically Necessary specialty physician services in accordance with the terms of an agreement with NHP.

Urgent care means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain), or which substantially restrict a Customer's activity (e.g., infectious illness, flu, respiratory ailments).

Eligibility

Verify eligibility of all NHP Customers before any services are rendered. You may verify eligibility in a number of ways. You may:

- Log on to myNHP.com
- Call our IVR System (877) 972-8845
- Call Customer Care (877) 972-8845

Verification of eligibility is not a guarantee of payment. NHP's website, myNHP.com, offers you and your office staff quick access to information that simplifies your administrative processes.

Through myNHP.com you may:

- Verify member's Primary Care Physician
- Obtain key member and claims statistics
- Verify member eligibility
- Submit a referral (only PCPs can submit referrals through myNHP.com)
- Check referral/authorization status
- View claims status

Support

NHP's website, myNHP.com, was designed to be easy to use with helpful tips and prompts. If you need further assistance, email NHP at providerrelations@mynhp.com or call (877) 972-8845, for support.

Site login and password

Go to the myNHP.com Provider Home Page and click "Access eServices." If your office does not have a password, the site will prompt you to obtain a password.

Interactive Voice Response (IVR) system

To check member eligibility through our IVR System, call (877) 972-8845.

You may call NHP's automated Customer Care 24 hours a day, seven days a week. You will need the member's 7-digit ID number to obtain the following member eligibility information:

- Enrollment status
- PCP name and number
- Office visit copay
- Inpatient copay
- Prescription drug copay (if applicable)

IVR system automated referral instructions

The NHP IVR System will simplify the process for routine specialist referrals for the PCP office staff. The IVR System is used to enter routine referrals to network specialists. **Only a PCP can refer a member to a specialist. A specialist cannot refer to another specialist.**

The NHP IVR System uses the telephone keypad to input numeric responses to generate a referral to a specialist within the NHP provider network. By following the instructional prompts, a referral can be processed in a matter of minutes.

The NHP IVR System uses the 12-digit PCP and specialist numbers which are printed in the IVR listing found in the mynhp.com website, and the member's 7-digit ID number printed on the ID card. PCPs will require a password and can only refer to specialists.

A referral authorization letter will be generated and mailed to the specialist and member within 24 hours after entry of the referral.

Referrals processed through the NHP IVR System are not guarantees of eligibility, benefit limitations, or coverage at the time of service. The authorization shall in no way limit or otherwise restrict the physician's ultimate responsibility for patient care and the provision of medical services.

How to use the IVR system

Please have the PCP number, PCP password, 7-digit member ID number, and the specialist number available. The PCP number and the specialist number are printed in the Provider Directory or found in the mynhp.com website. If you cannot locate the provider number, call Provider Relations (866) 582-7567.

To enter a referral call (877) 972-8845

Changes to the referral can only be made at the specific prompt and once you go to another referral or exit the system, the referral can no longer be deleted or changed.

To verify a referral call (877) 972-8845

The system will prompt you to the automated system. Press the correct prompt and follow directions.

Only those referrals entered through the IVR System within the last 180-days can be verified through the automated verification process.

Specialties for which a referral cannot be processed through the IVR system

Referrals to the following specialties cannot be processed through the NHP IVR System:

- Hematology
- Oncology
- Plastic & Reconstructive surgery
- Behavioral health services
- Perinatology
- Neonatology
- Ophthalmology Sub-Specialists (Retinal, Corneal, Occuloplasty)
- Infertility Specialists

In addition, there are services that require precertification or referral and cannot be processed through the IVR System. Please refer to the Utilization Management Section of this Supplement for a complete list. The PCP office will need to contact Medical Management at (877) 972-8845 or may fax the request to (800) 731-2515 or (800) 729-1574

NHP physician, hospital and ancillary provider responsibilities

As an NHP physician, hospital or ancillary provider, you accept responsibility for:

Responsibility	PCP	Specialty Care Physician	Hospital or Ancillary Provider
Providing coverage by a participating NHP provider, 24 hours a day, 7 days a week	X	X	
Providing or arranging for covered services to plan Customers.	X		
Accepting assigned members without discrimination or any screening of such Customers based on health status.	X		
Providing appropriate preventive measures including but not limited to, routine physical examinations, immunizations, hypertension screening and PAP smears.	X		
Providing Customers care and/or treatment without discrimination or any screening of such members based on health status.	X	X	X
Arranging for appropriate referrals to participating specialty care physicians for services not normally provided within the PCP's (your) scope of training and credentials.	X		
Providing covered services to plan Customers only upon receiving the appropriate referral authorization from an NHP PCP or health plan Utilization Management.		X	
Informing the PCP of the Customer's care. This includes informing the PCP of any testing, hospitalizations, or other care that is ordered or arranged to ensure continuity of care. For Specialty Care Physicians, this includes consulting with the Customer's PCP with respect to the Customer's care treatment and communicating the results of the consultation to the PCP having responsibility for the ongoing care of a particular member and providing a written report to the PCP within 7 days of the examination of the Customer.		X	X
Obtaining any required referrals and precertifications.		X	X
Retaining active and unrestricted admitting privileges at one or more participating hospital.	X	X	
Except in the case of Emergency Services, providing covered services to Customers only upon receiving the appropriate referral or precertification from an NHP PCP or NHP, as may be required.			X
Maintaining medical records relating to plan Customers in such a form as required by NHP guidelines and accepted medical practice.	X	X	X
Providing medical records as needed for compliance with state and federal laws and regulation and protect patient confidentiality.	X	X	X
Participating and cooperating with reasonable reviews and continuing education programs as requested by NHP.	X	X	X
Adhering to all applicable state and federal statutes, regulations and CMS guidelines and requirements.	X	X	X
Cooperating with NHP's Utilization Management, Quality Management and Customer Grievance policies, procedures and protocols.	X	X	X
Collecting applicable copayment, coinsurance, and deductibles only, and accepting NHP's reimbursement as a payment in full.	X	X	X
Not requiring a Customer to pay a "membership fee" or other fee in order to access your services and will not refuse any Customer based on failure to pay such fee.	X	X	
Not billing the member for services other than non-covered services and coinsurance, deductibles and co-payments; this includes missed appointments.	X	X	X
Communicating freely with Customers regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.	X	X	X
Submitting encounter/claims data for capitated or global services.	X	X	X
Providing Customers with appointments that are in compliance with NHP's accessibility standards.	X	X	
It is essential that all referrals are made to participating hospitals and physicians and that all services be arranged within the network.	X	X	X

Office administration

Discharge of a Customer from physician's care

If after reasonable effort, the physician is unable to establish and maintain a satisfactory relationship with a Customer, the physician may request that the Customer be discharged from care and transferred to an alternate physician. The physician must submit the request in writing to NHP Customer Care. Reasons for discharge include:

- Disruptive behavior
- Physical threats/abuse (This warrants immediate action which must be documented. Please contact NHP Customer Care and notify the proper authorities.)
- Verbal abuse
- Gross non-compliance with the treatment plan

Note: The PCP must provide adequate documentation in the member's medical record of the verbal and written warnings. The physician is obligated to provide care to the Customer until it is determined that the Customer is under the care of another physician.

Covering physicians

NHP physicians must arrange for coverage of their practice 24 hours a day, 7 days per week. The covering physician must be an NHP participating physician. If the covering physician is not in your group practice you must notify NHP to prevent claims payment issues.

Closing Customer panels

If a physician wishes to close his/her panel, the request must be made in writing 30 days in advance and state that the office is closing to all new patients, not only those of NHP. Once a panel is closed, it may not be opened to allow only select Customers to enter.

Referrals and precertifications

Providers must comply with NHP's Utilization Management and referral and precertification policies, procedures, and protocols. Except in the case of Emergency Services or when otherwise prior authorized by NHP, Provider shall refer Customers only to Participating Providers for Covered Services.

Specialist provider referrals

The PCP is responsible for determining when a "referral for specialty care" is needed. Initial referrals can only be initiated by the PCP. All referrals must be made to participating providers. Referrals to a specialist may be necessary:

- When a Customer fails to respond to current medical treatment,
- To confirm or establish a Customer's diagnosis and/or treatment modality,
- To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP.

PCP to participating specialist referrals are available in three levels and should be requested through the NHP website at myNHP.com or the IVR system for automated referrals by calling (877) 972-8845. Specialties not available through the website or the IVR are the following: Hematology, Oncology, Plastic and Reconstructive Surgery, Perinatology, Neonatology, Behavioral Health Services, Reproductive Endocrinology/Infertility Specialists and Ophthalmic Retinal Specialists.

Request for specialties not available through the IVR or the website can be sent to NHP Utilization Management at (800) 550-5568 or faxed to (800) 731-2515 or (800) 729-1574. Paper referrals may result in certification delays.

Request for a referral to a Behavioral Health provider may be directed to UBH by calling (800) 817-4705.

Level 1 One time consultation: This level certifies a specialist to see the Customer for one visit during a 60-day period. This referral does not authorize diagnostic testing or treatment.

Level 2 Consultation and diagnostic testing: This level certifies a specialist to see a Customer 3 times during a 90-day period. This covers diagnostic testing performed by the specialist in the office. Those services that require precertification are not covered by this referral. (See the *Precertification and referral list*, which follows in this section.)

Level 3 Consultation, diagnostic testing and treatment: This level certifies the specialist to see a Customer 3 times during a 90-day period. This covers diagnostic testing and treatment performed by the specialist in the office. Those services that require precertification are not covered by this referral.

Important facts

- Once the specialty services have been properly authorized, the Customer may schedule an appointment with the specialist. The PCP's office staff may also schedule the specialty appointment depending on the particular health care needs of the Customer.
- Faxed or mailed referrals will be date-stamped by the plan and processed in the order received and/or severity of the request as defined below. Urgent referrals ("Urgent," see definition below) will be handled on a priority basis. Such cases should be handled through the NHP website, IVR or Medical Management. (See the *Precertification and Referral List*, which follows in this section.)
- Definition of "Urgent" – Waiting the routine time period for a standard referral could seriously jeopardize the life or health of the Customer or the ability of the Customer to regain maximum function; or, in the opinion of a physician with knowledge of the Customer's medical condition, would subject the Customer to severe pain that cannot be adequately managed without the care or treatment.
- Should there be a question/concern regarding the referral, such as eligibility, coverage or medical necessity, the UM staff will notify the PCP's office staff.
- An authorization letter will be mailed to the specialist for retention in the Customer's medical record.
- Specialist claims will not be paid without a referral being on file. It is imperative that all referrals are submitted in a timely fashion.
- The specialist should re-verify the Customer's eligibility at the time of visit. This may be done by calling Customer Care at (877) 972-8845.

Referral form

The PCP may choose to complete the referral form, available on mynhp.com, for those specialties or services not available through the IVR.

The following information must be included in the referral form:

- **PCP information**
  - Name of the referring physician
  - Provider ID number
  - Phone number
  - Date of referral
- **Customer information**
  - Name
  - ID number and group number
  - Phone number
- **Specialist information**
  - Name
  - Address

    - Specialty
    - Phone number
- **Purpose of referral (one must be indicated)**
    - Level 1: One time consultation
    - Level 2: Consultation and diagnostic testing
    - Level 3: Consultation, diagnostic testing and treatment
- Documentation of any pertinent clinical summary information which would be helpful to the specialist or UM
- Referring PCP signature and date of referral Fax request form to Utilization Management: (800) 731-2515 or (800) 729-1574

Referrals

The following professional services do not require a referral:

- Chiropractic (subject to benefit limitations)
- Dermatology (5 visits per calendar year)
- Gynecology
- Podiatry
- Alcohol/chemical dependency treatment
- Mental health

The following professional services require coordination with the following entities.

- Home health: Advocare Health Alliance (305) 728-2747 or (866) 374-4326.
- Podiatry: Foot and Ankle Network (FAN): (305) 558-0444.
- Substance abuse and mental health treatment: UBH, (800) 817-4705.
- Outpatient therapy PT/OT/ST: ACN (OptumHealth) (800) 873-4575.
- Radiology Services: CareCore National (CCN) (For Precertification Services) (866) 242-9546

Precertification

Please refer to Protocol III for a Precertification and Referral List.

Additional specialist visits

1. If it is determined by the PCP that the Customer requires continued specialty visits or treatments by the specialist, additional visits may be requested by the PCP by submitting a Precertification form (treatment plan) to Utilization Management (UM).
2. The PCP may submit the Precertification form which is available on mynhp.com. The treatment plan must include the following information.
    - Date of request
    - PCP name
    - Customer name and ID number
    - Specialist name, phone number, and specialty
    - Pertinent medical information substantiating the need for additional visits
    - The number of additional visits requested and the timeframe for the visits
3. The Precertification form may be faxed to UM: (800) 731-2515 or (800) 729-1574

4. Upon receipt of the Precertification form, UM will review for medical necessity and appropriateness of care. A letter will be sent to the PCP, specialist, and Customer with the outcome of the decision. This letter should be filed in the Customer's medical record.
5. If the Precertification form treatment plan is authorized, it will be valid for a specific number of visits and/or treatments. Once the specific number of visits or authorized timeframe have been reached, whichever comes first, a new Precertification form treatment plan must be submitted for additional visits to be authorized. This is necessary to ensure proper claims payment.
6. The specialist should re-verify the Customer's eligibility at each visit to ensure that the Customer is still eligible under the health plan.

Out-of-network specialty referrals

1. Out-of-Network specialty referrals are only approved when the services required are not available within the network to ensure continuity of care.
2. All Out-of-Network specialty referrals must be precertified.
3. If services are requested as "Urgent," as defined in *Important Facts*, it will be processed in 24 hours upon receipt of request.
4. Out-of-network referrals may be requested by calling NHP. All providers must contact Utilization Management (UM) for authorization:

   NHP Utilization Management
   (800) 550-5568
5. Upon receipt of the referral by UM, the data will be reviewed and, if approved, entered into the system to ensure payment of the specialist claims.
6. Should there be a question/concern regarding the referral, such as eligibility, coverage, or medical necessity, the UM staff will notify the PCP's office staff.
7. The PCP will be verbally notified of the authorization and an authorization letter will be mailed to the Customer and the specialist for retention in the Customer's records.
8. The PCP's office must receive approval before sending the Customer to the specialist.
9. Upon authorization by UM, the PCP sends a copy of the referral to the specialist and retains a copy in the Customer's medical records.

Obstetrical referrals

1. Once it is determined or suspected that a Customer is pregnant, the Obstetrician may complete the Total OB Notification Form, which is available on mynhp.com.
2. A Total OB Care Notification Form is required for obstetrical care.
3. Indicate total OB care and the estimated due date on the referral form. The Total OB Care Authorization will cover all prenatal care and one ultrasound between 13 and 24 weeks of gestation, & delivery. All other obstetrical ultrasounds will require separate precertification.
4. High risk OB patients should be identified on the Total OB Notification form.
5. The following procedures will require additional precertification: amniocentesis, fetal echo, biophysical profiles, consult to specialist, and non-stress tests. Additional ultrasound will require documentation of medical necessity.
6. During pregnancy, the obstetrician may issue referrals. Total OB care should be billed at the time of delivery along with the hospital authorization number of the delivery.
7. Venipuncture performed outside of the Obstetrician's office requires precertification.

8. Laboratory services: LabCorp must be utilized for all laboratory services including any genetic testing. An alternative provider for genetic testing may be available. Please contact NHP Utilization Management.
9. Authorizations for the delivering hospital will be issued at the time of the total OB authorization request to the physician. A precertification will be required at the time of delivery.

Non-referral provider services

The following services do not require a referral from the PCP. The Customer has direct access to these services.

- Gynecology

Annual well woman exam – Please use diagnosis code V72.3 1 (includes pap smear and pelvic examination) and appropriate CPT code as listed below.

	Code	Age
New patient:	99384	12-17
	99385	18-39
	99386	40-64
	99387	65>
Established patient:	99394	12-17
	99395	18-39
	99396	40-64
	99397	65>

- Dermatology (5 visits per calendar year)
- Chiropractic (subject to benefit limitations)
- Mental health and substance abuse
- Podiatry

IMPORTANT: Precertification requirements still apply to non-referral providers.

Hospital admissions

1. All admissions must be to participating hospitals, unless an out-of-network admission has been approved by the plan or it is an emergency.
2. All inpatient admissions require precertification by NHP Utilization Management (UM). All emergency admissions require certification within one business day; including rollovers from outpatient surgery and observation admission. Only a PCP or an NHP designated hospitalist may serve as the admitting physician for inpatient services, unless NHP has provided prior written authorization for a particular specialist physician or category of specialist physician to serve as the admitting physician for members.
3. Participating providers must be used for all services required during the hospital stay unless precertified by UM.
4. Notify NHP UM for hospital precertification review.

   Phone: (800) 550-5568
   Fax: (800) 731-2515 or (800) 729-1574
5. NHP approved criteria are used for all hospital reviews. All questionable cases are referred to the medical director for review. Please refer to the criteria grid under Utilization Management Decisions.
6. Upon completion of the medical review, if criteria is not met, a certification/denial letter will be sent to the PCP, specialist (if applicable), Customer, and the hospital.
7. Concurrent review will be conducted through the hospital stay by Health Services. The attending physician may be contacted during the review process for additional information as necessary.
8. Discharge planning will be coordinated through UM in cooperation with the physician and the hospital

discharge planning staff.

9. If the treating physician would like to discuss a case with a Physician advisor, please call NHP Utilization Review.

Precertification timeframes

To efficiently and appropriately process requests for procedures that require precertification, Utilization Management (UM) encourages our providers to submit information at the time service is requested. Be sure to provide all the necessary information with your request. With complete information, UM can process precertification requests within the guidelines below. Refer to the NHP precertification and referral list for a complete list of services requiring precertification. For "Urgent" requests, please call Medical Management (800) 550-5568.

Precertification standards

Authorization Type	Definitions	Examples	UM decision timeframe with complete information
Pre-service non-urgent	Any prior request for service that is of non-urgent nature.	• Elective surgery • Sleep Study • Diagnostic tests (CT Scan, MRI, MRA) • CareCore National (866) 242-9546	15 calendar days of receipt of request.
Pre-service urgent	Any prior request for service.	• A request for suture removal follow up ER visit	24 hours of receipt of request.
Concurrent urgent	Any urgent request for an extension of a previously approved ongoing course of treatment over a period.	• Request for authorization of a Customer admitted on an emergency basis	24 hours of receipt of request.
Post service	A request for authorization on a previously rendered service.	• Emergent hospital admission to non-participating facility	30 calendar days of receipt of request.

If a request is received with insufficient information to make a determination, UM will contact the provider to submit the necessary information. In the event that our attempts to receive this information are unsuccessful, the Customer may be notified via mail of the specific information that is required to make the determination. This letter will, in turn, extend the timeframe in order to receive this required information. A decision due date will be included in this letter. If this requested information is not received by the decision due date, a decision will be made with the information that was made available to UM. Notification of the outcome will be sent to the Customer, PCP, and requesting provider.

Protocol I

Subject: Specialty referral process

Effective Date; 3/00

Revised Dated: 7/03, 3/10

All NHP HMO Customers require a referral before scheduling appointments for specialty services.

PCPs will request one of the following referral types:

- Level I - Consult: PCP is authorizing a consultation only. The PCP requires a written or verbal communication prior to authorizing additional services. This level certifies a specialist to see the Customer for one visit during a 60-day period.
- Level II - Consultation & Diagnostics: PCP is authorizing a consultation and diagnostic tests that will be performed by the specialist and billed by the specialist on the same day as the consultation. Specialized diagnostics tests that are identified on the precertification protocol are not covered as part of this referral. This level certifies a specialist to see the patient 3 times during a 90-day period.
- Level III - Consultation, Diagnostics & Treatment: PCP is authorizing a consultation and diagnostic tests and any treatment that will be performed by the specialist and billed by the specialist on the same day as the consultation. Specialized diagnostics and treatments that are identified on the precertification protocol are not covered as part of

this referral. This level certifies a specialist to see the patient 3 times during a 90-day period.

- Chronic care - PCP is authorizing 3 or more visits, diagnostic tests and/or treatments over a course of more than 90 days that will be performed by the specialist in the office and billed by the specialist. The referral needs to include a written plan of care. Specialized diagnostic tests and treatments that are identified on the precertification protocol are not covered as part of this referral.

IMPORTANT: Reimbursement for services that have not been authorized will be denied. The patient cannot be billed for these services unless they have signed a waiver of liability or the services are denied as non-covered services.

Protocol II

Subject: Clinical laboratory services

Effective Date; 3/1/00

Revised Dated: 10/05, 107, 3/10

All NHP Customers should be directed to LabCorp, Inc. service centers for outpatient laboratory procedures. If a physician draws the specimen in the office, the provider will be reimbursed a blood draw fee.

If the physician performs clinical laboratory services in the office and bills NHP for such services, the services will be reimbursed at the rate specified in the provider agreement. Reimbursement will be made only for the procedures approved according to the attached lab lists 1 & 2. Procedures noted on list 1 may be performed by any physician in the office in accordance with state and federal guidelines. Procedures on list 2 will only be reimbursed if the NHP physician who bills for the service is listed as the specialty type in column one.

Home healthcare agencies will be responsible for "drop off" of drawn specimens at one of the LabCorp, Inc. centers.

Hospital laboratory services associated with the following types of services will be reimbursed according to the hospital agreement:

- Emergency room
- Chemotherapy
- Ambulatory surgery
- Transfusions
- Hemodialysis

Skilled Nursing Facility (SNF) lab drawn at a skilled nursing facility must be processed by LabCorp, Inc.

NHP laboratory procedure list I

May be performed by any NHP physician, regardless of the physician's specialty.

Code	Description
81000	Urinalysis, non-automated, with microscopy, by dip stick or tablet reagent for bilirubin,glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity urobilinogen, any number of these constituents, with microscopy non-automated
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis, qualitative or semiquantitive, except immunoassays
81007	Urinalysis, bacteriuria screen, by non-culture technique, commercial kit (specify type)
81015	Urinalysis, microscopic only
81025	Urine pregnancy test
82270	Blood, occult; feces, one-three simultaneous determinations
82947	Glucose quantitative, blood (except reagent strip)
82948	Glucose blood, reagent strip

Code	Description
82962	Glucose blood, one-touch monitor
84703	Gonadotropin, chorionic (hCG); qualitative
85008	Manual blood smear examination without differential parameters
85009	Differential WBC count, buffy coat
85013	Spun microhematocrit
85014	Blood count, other than spun hematocrit
85018	Blood count, hemoglobin
85025	Hemogram and platelet count, automated, and automated complete differential WBC count (CBS).
85610	Prothrombin time
85730	Thromboplastin time, partial (PTT) plasma or whole blood
86308	Heterophile antibodies; screening
86317	Immunoassay for infectious agent antibody, quantitative, not elsewhere specified
86403	Particle agglutination, antibody (rapid strep screen)
86580	Skin test, tuberculosis, intradermal
86585	Tuberculosis, tine test
87070	Culture, bacterial, definitive (throat or nose)
87081	Culture, bacterial, screening only, for single organisms
87084	Culture, presumptive, pathogenic organism, screening only by commercial kit, with colony est. from density chart
87086	Culture, bacteria, urine, quantitative, colony count
87088	Culture, bacterial, urine, commercial kit
87177	Smear, primary source, with interpretation, wet and dry mount, for ova and parasites
87184	Sensitivity study, antibiotic, disk method, per plate (12 or fewer disks)
87205	Smear, primary source, with interpretation, routine stain for bacteria, fungi, or cell types
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacterial, fungi, ova and/or parasites
87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, group A –
89055	Leukocyte Cout, Fecal
89230	Sweat collection by iontophoresis

Specialty specific lab services laboratory procedure list II

NHP will reimburse only NHP physicians in the specialty noted in column one of specific lab services listed for that specialty.

Specialty	Code	Description
Hematology	85007	Blood smear, microscopic examination with manual differential WBC count
	85025	Automated CBC/platelet/complete differential
	85027	Automated hemogram and platelet count
	85060	Blood smear, peripheral
	38220	Bone marrow, aspiration only
	85097	Bone marrow, smear interpretation only, with or without differential cell count
	38221	Bone marrow biopsy, needle or trocar
	G0306	Complete CBC, automated (HGB, HCT, RBC, WBC w/o platelet count)
	G0307	Complete CBC, automated (HGB, HCT, RBC, WBC)
Urology/Infertility	*Semen Analysis:*	
	89257	Sperm identification from aspiration (other than seminal fluid)
	89260	Sperm isolation: simple prep (*e.g.*, Sperm Wash and swim-up) for insemination or diagnosis with semen analysis
	89261	Sperm isolation, complex prep
	89300	Presence and/or motility of sperm including Huhner test (post-coital)
	89310	Motility and count
	89320	Complete (volume, count, motility and differential)
	89325	Sperm antibodies
Rheumatology	89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
	85651	Sedimentation rate, erythrocycte: non-automated
Infectious Disease	85652	Sedimentation rate automated
OB/Gyn	87110	Chlamydia culture
	89330	Sperm evaluations cervical mucus penetration, with or without Spinnbarkeit test
Gen.Surgery/Radiology/ Endocrinology	*Fine needle aspiration with or without preparation of smears:*	
	10021	Superficial tissue (e.g., thyroid, breast, prostate)
	10022	Deep tissue under radiologic guidance
All Outpatient Facilities	82247	Bilirubin, total (for members under 30 days old, if LabCorp, Inc. unable to draw)
	82248	Bilirubin, direct (for members under 30 days old, if LabCorp, Inc. unable to draw)
	82800	Blood gases (ABG) X pH only
	82803	Blood gases (any combination of pH, pCO2, p02, C02, HC03)
	82805	With oxygen saturation, by direct measurement, except pulse oximetry
	82810	Bloodgases, oxygen saturation only
	82820	Hemoglobin X oxygen affinity (p02 for 50% saturation with oxygen)
	83850	Antibody screen, RBC, each serum technique
	86860	Antibody elution (RBC), each elution
	86870	Antibody identification. RBC antibodies, each panel for each serum technique
	86900	Blood typing, ABO
	86901	Blood typing (Rh)
	86903	Antigen screening for compatible blood unit using patient serum, per unit screened
	86904	Antigen screening for compatible blood unit using patient serum, per unit screened
	86905	RBC antigens, other than ABO or Rh (D), each

Specialty	Code	Description
	86906	RH phenotyping complete
	87070	Microbiology, any other source
	87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Streptococcus, group A
	89190	Nasal smear for eosinophils
	89230	Sweat collection by iontophoresis
Hematology/Oncology/ Neurology/Pediatrics	*Lumbar puncture:*	
	82947	Glucose, quantitative
	84155	Protein, total, except refractometry
	85007	Blood count, manual differential WBC count
	89050	Cell count, miscellaneous body fluids, except blood
	82948	Glucose; quantitative, blood (except regent strip)
Cardiology/Cardio-Vascular/ Thoracic Surgery	85610	Pro thrombin time
	85730	Thromboplastin time, partial (PTT); plasma or whole blood
Pediatrics & Family Medicine	82247	Bilirubin, total (for members under 30 days old)
	82248	Bilirubin, direct (for members under 30 days old)

Protocol II-A

Subject:

Effective Date; 3/1/07, 3/10

- This Protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals.
- This Protocol does not apply to laboratory services that are approved to be provided by physicians in their offices.
- This Protocol does not apply where the physician bears financial risk for laboratory services.

You are required to refer laboratory services to Labcorp, except as otherwise authorized by NHP. Services can be obtained by either sending your NHP patient to a LabCorp drawing center or by obtaining the laboratory specimen from the patient and then sending the specimen to LabCorp. To get more information on local LabCorp sites in your area, you can:

- Go to mynhp.com to view a complete list of participating laboratories.

or

- Go to LabCorp.com or call (888)LABCORP (522-2677) Option #3 to determine how to conveniently access their services.

If you need assistance in locating or using a participating laboratory provider, we are also prepared to respond to your information needs via Customer Care at (877) 972-8845.

We are aware of the vital importance of laboratory services to your patients, and we are committed to maintaining a laboratory network that is both reliable and affordable.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact Customer Care at (877) 972-8845.

NHP recognizes that in some instances, physicians need immediate lab results in order to determine the best course of treatment for the Customer. We have developed a list of procedures for which we will reimburse all physicians when performed in the office (see Protocol II, List I). In addition, Protocol II, List II indicates those laboratory services which, when performed by the designated specialty, will be reimbursed to the provider by NHP.

NHP reimburses providers for phlebotomy, unless the provider is reimbursed under a capitation methodology or the laboratory service is performed in the physician's office. Claims must be submitted using a valid CPT code.

LabCorp requires the following to ensure accurate testing and billing:

- Customer's NHP ID number
- LabCorp requisition forms with all required fields completed specific test orders using test codes
- Diagnosis (ICD-9) codes

Administrative actions for out-of-network laboratory services referrals:

NHP network physicians have long demonstrated their commitment to affordable health care by making extensive use of participating laboratories. We anticipate that virtually all participating physicians will be able to easily find that Labcorp will meet their needs.

If NHP determines an ongoing and material practice of referrals to non-network laboratory service providers, NHP will promptly notify the responsible physicians of the issue and remind them of their contractual requirements. Moreover, while it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions:

- a decreased fee schedule; or
- termination of network participation, as provided in your Participation Agreement.

It is the intent of NHP to work with participating physicians to promote network viability and stability, and to maximize the value of in-network laboratory services. Our expectation is that this collegial approach will continue to succeed, and that the interventions listed above will be applied only in rare circumstances, if at all. Please contact Network Management at United Healthcare if you have any questions about making effective use of our participating laboratory network.

Protocol III

Subject: Precertification process

Effective Date; 3/00

Revised Dated: 11/07, 3/10

All NHP Customers require prior certification for the services listed on the attached precertification list.

All providers of services must call NHP for precertification. Our staff is accessible to callers who have questions about the UM process at the toll-free number listed on page 1.

A plan provider must provide all services at a plan facility unless an out-of-network certification has been issued by NHP UM.

All inpatient admissions, including hospitals, acute rehabilitation facilities and skilled nursing facilities, must be precertified prior to admission with the exception of admissions from the emergency room and admissions to the ICU/CCU or admission for emergency surgery. NHP must be notified by the next business day following the admission, if the admission occurs as a result of the above exception.

The provider must provide clinical information that justifies the medical necessity of the admission, by the next business day following the admission. Criteria are used to review all admissions and surgical procedures. All questionable cases will be referred to the medical director for final determination.

All discharge planning, and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management, including all OB care.

If the diagnosis or treatment of a Customer is delayed secondary to the inability of the facility to provide a needed service, payment for these days will be denied. This includes, but is not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

NHP Precertification list

The following professional services require coordination or precertification with the following entities:

DME, Home health and Home Infusion services: Advocare Health Alliance - (305) 728-2747 or (866) 374-4326
Podiatry Services: Foot and Ankle Network (FAN) - (305) 558-0444
Substance abuse and mental health treatment: United Behavioral Health (UBH) at (800) 817-4705
Oncology Services (other than pediatric and specific skin cancers): NHP Medical Management (800) 550-5568
Outpatient Therapy PT/OT/ST: ACN (800) 873-4575.
Radiology/Cardiology/Nuclear Imaging Services: CareCore National (CCN) : (866) 242-9546 Fax: (866) 466-6964

Precertification

The following services must be precertified before services are rendered in order for such service to be payable. Contact Medical Management at (800) 550-5568.

- Inpatient: hospital (including observation), psychiatric, rehab, and SNF
- Surgery and invasive procedures: performed in an outpatient hospital or ambulatory facility (with the exception of Colonoscopies for members 50 years of age and older; and Sigmoidoscopies).
- Implantable cardiac defibrillators, ventricular assistance devices, and lung volume reduction surgery procedures, even if the inpatient admission has been authorized.
- Sleep Study
- MRI, MRA, CT Scans, CTA scans, PET scans:(Care Core National CCN (866) 242-9546)
- Nuclear Medicine Imaging, including without limitation:
    - Pulmonary perfusion/ventilation
    - Venous imaging
    - Nuclear bone scans
    - Echo stress test
    - Bone marrow imaging
    - Thyroid imaging
    - Liver/Spleen imaging
    - Brain imaging
- Nuclear stress tests, including without limitation thallium, technetium, Cardiolite, Myoview, sestamibi; and myocardial perfusion and ejection fraction, and wall motion studies. Nuclear stress tests encompass nonpharmacological (exercise) and pharmacological stress tests, including without limitation, adenosine, persantine and dobutamine.
- Invasive vascular studies and procedures/EP studies
- DME: (Advocare Health Alliance (305) 728-2747 or (866) 374-4326)
- Insulin Pumps and supplies
- Prosthetic and orthotic devices
- Home healthcare: (Advocare Health Alliance (305) 728-2747 or (866) 374-4326)

- Sleep studies
- Outpatient therapy: physical, occupational, speech: ACN Group, INC. (800) 873-4575
- Outpatient: Cardiac and Pulmonary rehab
- Hyperbaric oxygen treatment
- Wound care
- Mental health/substance abuse: UBH (800) 817-4705
- Dialysis
- Chemotherapy (chemotherapeutic agents regardless of indication), radiation therapy, transfusions, infusions
- Chronic specialist care
- Pain management
- Hospice
- Total OB Care, including one screening OB ultrasound for fetal anatomy performed between 13-24 weeks of gestation. All ultrasounds performed for specific clinical indications require a separate authorization, and are reviewed for medical necessity.
- Biophysical profiles and amniocentesis
- Drugs: refer to Protocol V.
- Laboratory services
- Any services not provided by LabCorp, Inc., and not listed on the NHP Protocol II;
- Dermatology:

CPT	Procedure
77401 – 77416	Grenz X-ray therapy
14000 – 14350	Adjacent Tissue Transfer
15000 – 15401	Free skin grafts
15570 – 15738	Flaps
15740 – 15776	Other flaps and grafts
15780 – 15879	Other procedures

- Ambulance service
- Genetic Testing
- All out of network and out of area services

Note: Reimbursement for services that have not been precertified will be denied. The Customer cannot be billed for these services unless they have signed a waiver of liability or the service is denied as non-covered services. The Customer is held harmless in these proceedings. Physicians may be reimbursed for their services when the facility fails to precertify the required services and the services were for an emergency medical condition.

Protocol IV

Subject: Concurrent review process

Effective Date; 1/01

Revised Dated: 7/03, 3/10

NHP requires all hospital, inpatient rehabilitation facility and skilled nursing facility admissions to be precertified prior to admission with exception of admissions from the emergency room and admissions to the ICU/CCU or admission for emergency surgery. NHP or its delegated entities must be notified by the next business following admission if the

admission occurs as a result of the above exception.

The provider must provide clinical information that justifies the medical necessity of the admission, by the next business day following the admission. All questionable cases will be referred to the medical director for final determination.

The continued stay for all inpatient admissions must be certified through the concurrent review process. Upon request, the provider must submit to NHP or its delegated entities, by phone, or fax, sufficient clinical information to justify the continued stay and to allow the review of the Customer's medical status during an inpatient stay, extend the Customer's stay, coordinate the discharge plan, determine medical necessity at an appropriate level of care, and to perform quality assurance screening.

All discharge planning, and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management, including OB care.

If the diagnosis or treatment of a patient is delayed secondary to the inability of the facility to provide a needed service, payment for these days will be denied. This includes, but is not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

Note: Reimbursement for continued stay that does not meet NHP medical necessity criteria will be denied. The patient cannot be billed for these services unless they have signed a waiver of liability or the services are denied as non-covered services. The Customer is held harmless in these proceedings.

Protocol V

Subject: Drug prior authorization

Effective Date: 04/0

Revised Date: 08/05, 04/06, 12/06, 2/08, 4/09, 1/10

NHP's pharmacy benefit manager is UnitedHealth Pharmaceutical Solutions, which uses Medco Health Solutions, Inc. (Medco) for certain pharmacy benefit services. In order to promote appropriate utilization, NHP requires a prior authorization (PA) for selected medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician's service (medical benefit) to be eligible for coverage. PA criteria have been established with input from physicians and consideration of current medical literature. The PA list and criteria are dynamic and reflect the P&T Committee's review and responsiveness to the needs of Customers and network physicians. For a Customer to receive coverage for a medication requiring PA, the physician must provide clinical information to Medco. (if the medication is to be dispensed by a participating pharmacy), or to NHP UM (if the medication is to be provided incident to a physician's service). PA does not guarantee coverage.

All infusions and chemotherapeutic agents, regardless of indications, require prior auth from NHP Medical Management (UM). In addition, all the following require PA:

Drug name	Criteria	PA through PBM drug available at pharmacy	PA through NHP drug available at physician office only
Actiq (fentanyl)	Coverage is provided only for the management of breakthrough cancer pain in Customers with malignancies who are already receiving and who are tolerant to opioid therapy, for their underlying persistent cancer pain.	X	
Alpha Interferons and Ribavarin	Coverage is provided for a broad range of indications such as chronic hepatitis, hairy cell leukemia, and non-Hodgkins lymphoma	X	
Alferon	Coverage is provided for intralesional treatment of refractory or recurring external condylomata acuminate in Customers 18 years of age or older		X
Amevive	Coverage is provided for treatment of adults with moderate to severe plaque psoriasis		X
Amitiza (requires PA eff. 04/08)		X	
Avodart	Coverage is provided for males with benign prostatic hyperplasia	X	
Botox Dysport Myobloc	Coverage is provided for treatment of cervical dystonia, strabismus and blepharospasm associated with dystonia, spasmodic dystonia (laryngeal dystonia), hand dystonia (writer's, musician's or typist's cramp), hand tremor, voice tremor, cerebral palsy associated spasticity, stroke associated spasticity, multiple sclerosis associated spasticity, chronic anal fissures, achalasia, hyperhidrosis, piriformis syndrome, hemifacial spasm, sialorrhea, detrusor-sphincter dyssynergia, and oromandibular dystonia.		X
Celebrex	Coverage is provided for Customers who have tried and failed 3 generic NSAIDs	X	
Cerezyme	Coverage is provided for Enzyme Replacement		X
Diflucan	Coverage is provided for one course of treatment for onychomycosis. Unlimited courses of treatment for any other fungal infection	X	
Differin	Coverage is provided for the treatment of acne vulgaris or actinic keratoses for Customers greater than age 25	X	
Enbrel	Coverage is provided for treatment of moderately to severely active rheumatoid arthritis. Treatment of psoriatic arthritis and ankylosing spondylitis. Treatment of moderate to severe plaque psoriasis.	X	
Epogen, Procrit, Aranesp	Coverage is provided for the diagnosis of anemia associated with chronic renal failure; HIV-infected Customers with diagnosis of anemia; diagnosis of malignancy where anemia is due to the effect of chemotherapy or a complication of the cancer and the Customer is not receiving chemotherapy	X If disp. through pharmacy	X If administered through MD office
Fentora	Coverage is provided only for the management of breakthrough cancer pain in Customers with malignancies who are already receiving and who are tolerant to opioid therapy, for their underlying persistent cancer pain.	X	
Ferrlecit	Coverage is provided for the treatment of iron deficiency in Customers undergoing hemodialysis and receiving supplemental erythropoietin therapy	X	
Growth Hormones (Somatropin) Increlex Serostim Zorbtive	Coverage is provided for the treatment of documented growth hormone deficiency, including pediatric growth hormone deficiency and adult growth hormone deficiency syndrome, and other disorders affecting growth in children, including gonadal dysgenesis, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, Prader-Willi syndrome, and growth failure in children born small for gestational age Coverage is provided in situations where the Customer is being treated for severe primary IGF-1 deficiency or with growth hormone gene deletion who have developed neutralizing antibodies to growth hormone. Coverage is provided for the treatment of wasting associated with AIDS Covered is provided for treatment of short bowel syndrome.	X	
Humira	Coverage is provided to reduce the signs and symptoms and inhibit the progression of structural damage in adult Customers with moderately to severely active rheumatoid arthritis who have had an inadequate response to disease modifying antirheumatic drugs (DMARDs) when prescribed by a rheumatologist	X	
Kineret	Coverage is provided for treatment of moderately to severely active rheumatoid arthritis, in Customers 18 years of age or older who have failed one or more DMARDs.	X	

*Note: Not intended as claims coverage guidelines

*Drugs which are considered to be self-injectable are not covered in the physician's office

Drug name	Criteria	PA through PBM drug available at pharmacy	PA through NHP drug available at physician office only
Lamisil	Coverage is provided for one course of treatment for onychomycosis. Unlimited courses of treatment for any other fungal infection	X	
Lotronex	Coverage is provided for treatment of severe diarrhea predominant irritable bowel syndrome, when the Customer is female at least 18 years old and has failed conventional therapy.	X	
Neupogen/ Neulasta	Coverage is provided for treatment of neutropenia and in bone marrow transplantation	X If disp. through pharmacy	X If adminis-tered through MD office
Proton Pump Inhibitors (Tier 3 brands)	Coverage is provided for Customers who have tried and failed Tier 2 brands	X	
Prolastin	Coverage is provided for a diagnosis of congenital alpha 1-antitrypsin deficiency with emphysema		X
Proscar	Coverage is provided for males with benign prostatic hyperplasia	X	
Provigil	Coverage is provided for narcolepsy, idiopathic hypersomnolence, multiple sclerosis-related fatigue, and shift work disorder	X	
Raptiva	Coverage is provided for treatment of chronic plaque psoriasis in adults	X	
Regranex	Coverage is provided for the treatment of lower extremity diabetic neuropathic ulcers	X	
Remicade Orencia	Coverage is provided for the treatment of moderate to severe rheumatoid arthritis (RA), rapidly advancing, progressive RA, moderate to severe psoriatic arthritis, moderate to severe Crohn's disease, fistulizing Crohn's disease, ankylosing spondylitis, and ulcerative colitis		X
Restasis	Coverage is provided for treatment of keratoconjunctivitis sicca or for corneal inflammatory conditions where the use of extemporaneously compounded cyclosporine ophthalmic preparations would be required	X	
Retin A, Avita	Coverage is provided for treatment of medical skin conditions (e.g., treatment of acne vulgaris, actinic keratoses, precancerous skin lesion). PA required for Customers >25 years.	X	
Revatio	Coverage is provided for treatment of pulmonary arterial hypertension	X	
Stimulants amphetamine salts (Adderall/Adderal l methylphenidate (Ritalin/Ritalin SR/Ritalin LA, Concerta, Metadate CD/Metadate ER), dextroamphetamine (Dexedrine), methamphetamine (Dexosyn), dexmethylphenida te (Focalin), atomoxetine (Strattera)	Coverage is provided for treatment of attention deficit hyperactivity disorder, narcolepsy and idiopathic somnolence, fatigue associated with multiple sclerosis, and refractory depression.	X	
Synvisc, Synvisc-One, Euflexxa, Othovisc Hyalgan & Supartz	Coverage is provided for mild to moderate osteoarthritis not responsive to analgesics or other conservative therapy. Customer must not be markedly obese or have large effusions. Only approved for osteoarthritis of the knees List as preferred Buy and Bill or Specialty Pharmacy Required to go through Specialty Pharmacy		X
Synagis & Respigam	Coverage is provided for RSV		X
Sporanox	Coverage is provided for one course of treatment for onychomycosis. Unlimited courses of treatment for any other fungal infection	X	

*Note: Not intended as claims coverage guidelines

*Drugs which are considered to be self-injectable are not covered in the physician's office

Drug name	Criteria	PA through PBM drug available at pharmacy	PA through NHP drug available at physician office only
Suboxene/Subutex (requires PA eff. 04/08)		X	
Tazorac	Coverage is provided for treatment of plaque psoriasis and acne vulgaris	X	
Tracleer	Coverage is provided for treatment of pulmonary arterial hypertension	X	
Ventavis	Coverage is provided for treatment of pulmonary arterial hypertension	X	
Wellbutrin SR	Coverage is provided for treatment of depression	X	
Wellbutrin XL	Coverage is provided for treatment of depression	X	
Xolair	Coverage is provided for treatment of moderate to severe persistent asthma in adults and adolescents who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids	X	
Zavesca	Coverage is provided for treatment of adult Customers with mild to moderate type I Gaucher disease for whom enzyme replacement therapy is not a therapeutic option	X	
Zoladex	Coverage is provided for treatment of prostate cancer, endometriosis and advanced breast cancer	X	
Zyvox	Coverage is provided for treatment of infections caused by susceptible strains of Vancomycin-Resistant Enterococcus faecium; nosocomial pneumonia caused by Staphylococcus aureus, or Streptococcus pneumoniae; complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae; uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin-susceptible only) or Streptococcus pyogenes; community-acquired pneumonia caused by Streptococcus pneumoniae, or Staphylococcus aureus (methicillin-susceptible strains only).	X	

Medco Drug PA Requests
Telephone: (800) 753-2851
Fax: (800) 827-0959

(all fax requests are responded to in 24 hours)

NHP Drug PA Requests
Telephone: (877) 488-5576
Fax: (800) 731-6984

Claims inquiries and appeals

NHP has a formalized process for handling provider claim inquiries and claim appeals. Following are the details of when and how to utilize each of these processes.

Claim inquiry

- What: A request may be sent either verbally or electronically to request a review of a particular claim, or a further explanation regarding the disposition of a claim.
- How: Contact Customer Care at (877) 972-8845 or submit your request online at uhcrivervalley.com (Documentation sent to the plan should clearly explain the nature of the review request.)
- Who: The provider or the office staff of the provider may request a claim inquiry.

NHP will respond to you in writing on all claim inquiries that do not result in the re-adjudication of the claim. You must file a claim inquiry before you file a claim appeal.

*Note: Not intended as claims coverage guidelines

*Drugs which are considered to be self-injectable are not covered in the physician's office

Claim appeal

- What: A written request for the purpose of requesting NHP to reconsider its decision on how a claim was originally processed.
- How: Claim appeals must be requested in writing. Please use the Provider Appeal Request Form available on mynhp.com.
- Who: The provider or the office staff of the provider may request a claims appeal.
- Where: Claim appeal forms, along with all accompanying documentation, should be mailed to:

NHP Provider Claims Appeals
PO Box 025680
Miami, Florida 33102-5680

Customer grievance and appeals

There are situations when Customers have questions about their coverage or are dissatisfied with NHP services. Such questions and Complaints will be handled by NHP in a timely manner. Questions relating to the Agreement should be addressed by members to Customer Care.

Grievances and Appeals will be addressed to the Grievance Coordinator who is the person responsible for the maintenance of records and for the supervision of the Grievances and Appeals process for NHP. A specific set of records will be maintained to document Grievances and Appeals filed. Records will include the reason for Grievances and Appeals, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Coordinator.

Complaint procedures

NHP encourages Customers to resolve individual inquiries and problems without the initiation of a formal Grievance. Any Customer who has an inquiry or Complaint regarding a matter arising under the Agreement should contact Customer Care for verbal resolution. A Customer Care Representative will respond to the Customer's inquiry or complaint promptly.

Formal grievance procedure

In the event the Customer's problem has not been settled at the informal level and the Customer is still dissatisfied, the Customer will be advised to file a formal written grievance. This is called a Level I Grievance. Grievances must be submitted within 180 days of occurrence (i.e. the date when the issue, and subject of the Grievance, is known to Customer). Grievance forms are available from NHP by writing to the address below. Additional information or assistance in preparing the written Grievance may be obtained by contacting Customer Care.

The Grievance must contain the following information:

1. The Customer's name, address and ID number;
2. A summary of the Grievance, any previous contact made with NHP, and a description of relief sought;
3. The Customer's signature; and
4. The date the Grievance is signed.

The written Grievance must be mailed to the following address:

NEIGHBORHOOD HEALTH PARTNERSHIP
P.O. Box 025680
Miami, FL 33102
Attn: Grievance Coordinator

PacifiCare Non-Capitated Supplement

Important information regarding the use of this supplement

This supplement is intended for use by non-capitated physicians, health care professionals, facilities and ancillary providers who provide services to Customers enrolled in benefit plans insured by or receiving administrative services from one or more of the following PacifiCare family of companies: Insurance coverage provided by or through PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company or their affiliates. Health plan coverage provided by or through PacifiCare of Arizona, Inc., PacifiCare of California, PacifiCare of Colorado, Inc., PacifiCare of Nevada, Inc., PacifiCare of Oklahoma, Inc., PacifiCare of Oregon, Inc., PacifiCare of Texas, Inc., PacifiCare of Washington, Inc. Administrative services provided by PacifiCare Health Plan Administrators, Inc., UnitedHealthcare Insurance Company, United HealthCare Services, Inc., Prescription Solutions, Ingenix, Inc. or ACN Group. This supplement applies to behavioral health products provided by PacifiCare Behavioral Health, Inc. (PBHI) or United Behavioral Health (UBH), and benefit plans offered under Oklahoma Policy Numbers OKEOC2010, GHC-SMGRP-2006-OK, and GHC-LGGRP-2006-OK.

This supplement refers to a "Customer" as a person eligible and enrolled to receive coverage from a payer for covered services as defined in your agreement with us. (Your contract may use the term "member"). "You" or "your" refers to any provider subject to this supplement as described above, unless otherwise specified in that specific section. All referenced items are applicable to all providers subject to this supplement. "Us," "we" or "our" refers to any PacifiCare legal entity or affiliate named above.

Former references to any PacifiCare "Provider Manual," other than the PacifiCare Capitated Administrative Guide, are replaced with this supplement, in conjunction with the core "UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide".

Note: Please be aware that there may be changes in 2011 to the PacifiCare name and the branding associated with the family of PacifiCare companies listed above. If and when these changes occur, we will communicate with you about them.

How to contact us

Resource	Where to go	What you can do there
PacifiCare® Provider Portal	PacifiCare.com	• Register for PacifiCare.com • Check claim status • Access commonly used forms • View Customer eligibility information, up to 10 Customers at a time • View the formulary • Access iEXCHANGE™ (online Hospital Admissions, Authorizations & Referrals) (as applicable per region) • View the provider directory • Access Provider Policy and Procedure Guides • View the retail pharmacy directory • Use the Library/Resource Center • Review/print a current copy of this supplement • Find Electronic Data Interchange (EDI) and Clearinghouse information • Access product information • Create individual user accounts for office staff • Take a virtual tour of PacifiCare.com to help you navigate our website • Contact us via secure email by clicking on "Contact Us"
	(800) 693-8322	• Receive technical support and assistance with registration, access and use of PacifiCare.com
Preauthorization (Non-delegated)**:** • For urgent requests • For routine requests	***Arizona*** (800) 746-7405 Fax: (800) 283-7523 ***California, Oregon and Washington*** (800) 762-8456 Fax: (866) 718-6105 ***Colorado*** (800)746-7405 Fax: (800) 283-7523 ***Texas and Oklahoma*** (800) 668-8139 Fax: (800) 438-5470 ***Nevada*** (800) 337-8114 Fax: (800) 537-3992	• Request urgent preauthorization approval • Request routine preauthorization approval
Hospital Inpatient Notification (Non-delegated)**:**	***Colorado only*** (866) 822-0591 Fax: (888) 714-3991 Inpatient & observation (800) 799-5252 Fax: (800) 274-0569 ***Mental health*** Commercial: (800) 430-0033 Medicare Advantage: (800) 508-0088 ***Transplant*** (866) 300-7736 Fax: (888) 361-0502	• Notify us of any admission
Electronic Claim Submission **Technical Support** **Encounters EDI Enrollment**	PacifiCare.com (800) 203-7729 edisupport@uhc.com encountercollection@uhc.com	• Review EDI tools and Services under "Quick Link" and "Service and Tools" • Access EDI and clearinghouse information under "Library" and "Resource Center" • Obtain information on submitting claims electronically

Resource	Where to go	What you can do there
Enhanced Voice Portal	Commercial & Medicare Advantage HMO/MCO: California: (800) 542-8789 Arizona: (800) 283-7525 Colorado: (800) 831-4388 Nevada: (800) 501-1199 Oklahoma: (877) 847-2862 Oregon: (800) 920-9202 Texas: (877) 847-2862 Washington MCO: (800) 213-7356	• Check eligibility: › Access Primary Care Physician assignment › Verify Plan Code › Verify Provider History › Access Coverage History • Check copay and benefits • Check claim status (TIN required) • Quick FAX (eligibility and claims) • Pharmacy approval • Prior authorization • Inpatient notification
iEXCHANGE™ (Online Hospital Admissions, Notifications, and Authorizations Requests)	PacifiCare.com → Login → Services and Tools → iEXCHANGE (The iEXCHANGE portal is available in CA, OK, OR, TX, and WA. It is not currently available in AZ, CO and NV.)	• Request routine and urgent preauthorizations and extensions and receive immediate status feedback • Receive a tracking number upon submission of a request, which can be used to track the case status or request an extension to the initial request • Receive alerts from PacifiCare when a request is reviewed and updated by the Medical Management department • Provide clinical notes to PacifiCare in the comments section • Check Customer eligibility and look up existing authorizations online • Submit inpatient admission notifications and outpatient authorization information • Print copies of authorization requests
Standard Customer Appeals (applies only to commercial PacifiCare SignatureValue® HMO/MCO and PacifiCare SugnaturePOS® POS)	**Arizona, Nevada, Colorado** P.O. Box 4306 Mail Stop CO030-1000 Englewood, CO 80155-4306 Fax: (866) 449-2847 ***AZ/NV Phone: (***800) 347-8600 ***CO Phone: (***800) 877-9777 **California** Mail : P.O. Box 6107 Mailstop CA124-0160 Cypress, CA 90630 Fax: (866) 704-3420 Phone: (800) 624-8822 **Oklahoma, Oregon, Texas, Washington** Mail: P.O. Box 400046 San Antonio, TX 78229 Fax: (888) 615-6584 ***OK/TX Phone:*** (800) 825-9355 ***OR/WA Phone:*** (800) 932-3004	• Request a standard decision on an appeal
Expedited Appeals (applies only to Commercial HMO/POS) PacifiCare SignatureValue® HMO/MCO and PacifiCare SignaturePOS® (POS)	**Arizona, Nevada, Colorado** ***AZ/NV Phone:*** (800) 347-8600 CO Phone: (800) 877-9777 Fax: (866) 449-2903 **California** Phone: (888) 277-4232 Fax: (800) 346-0930 **Oklahoma, Oregon, Texas, Washington** Phone: (800) 267-7516 Fax: (888) 615-6584	• Request an expedited decision on an appeal

Resource	Where to go	What you can do there
Pharmacy Services	For Commercial products: PacifiCare.com For Medicare products: SecureHorizons.com → Search the Drug List AARP®MedicareComplete.com→ Search the Drug List Evercarehealthplans.com → What We Offer → Medicare Plans → Part D prescription drug benefits	• Access formularies, preauthorization guidelines and after-hours procedures, 24 hours a day, 7 days a week • View the SecureHorizons® Formulary or request a copy • View the Evercare Formulary
	Phone: (800) 711-4555 Fax: (800) 527-0531 Fax: (800) 853-3844 Website: PrescriptionSolutions.com	• Request a prior authorization • For oral medications • For injectable medications
	(866) 798-8780, Option 2 (applies only to Medicare Advantage products)	• Request information on the Medicare Part D Medication Therapy Management Program
Mental Health, Substance Abuse/Substance Use, Vision or Transplant Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's behavioral health, substance abuse, substance use, vision or transplant benefits
California Language Assistance Program (applies only to Commercial products in California)	PacifiCare.com → Provider → Spotlight → California Regulation SB 853 - Language Assistance Program Information	• Access information regarding the California Language Assistance Program
Health Management and Disease Management Programs	PacifiCare.com → Login → Providers → Library → Click on the desired state → Forms To enroll patients: Phone: (877) 840-4085 Fax: a completed referral form to (877) 406-8212	• Access referral forms for Disease Management and Health Management information

Health care identification cards

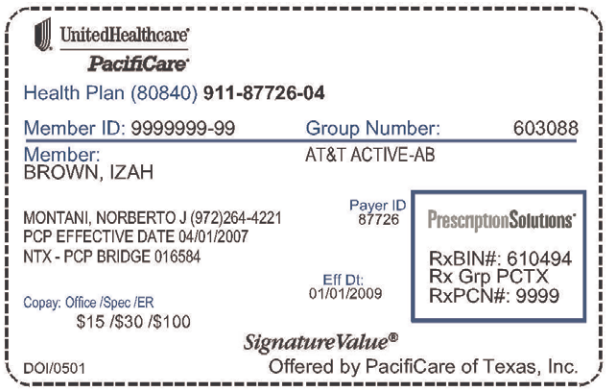
Each Customer receives a health care identification (ID) card containing information that helps you submit claims accurately. Information may vary in appearance or location on the card due to payer or other unique requirements. It is important to check the Customer's health care ID card at each visit and to keep a copy of both sides of the card for your records.

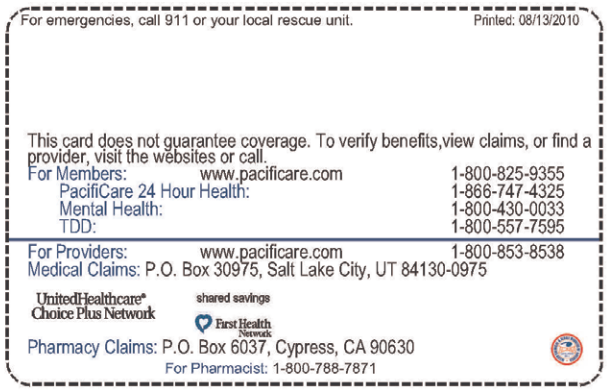
Sample health care ID cards

Medicare Advantage products

To help identify Customers associated with Medicare Advantage products offered through the AARP® MedicareComplete, SecureHorizons, Evercare, UnitedHealthcare and Erickson Advantage brands, please go to the following provider website for ID card guides: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → 2011 UnitedHealthcare Medicare Solutions Physician/Provider Information → Scroll to "Customer ID Card Information" section at the bottom of the page.

PacifiCare Commercial health care ID card (generic)





Our products

We offer a wide range of products and services for employer groups, families and individual Customers. Plan availability may vary. Contact us for more information about plan availability and service areas where each of these products and supplemental benefits are available.

PacifiCare Commercial product - PacifiCare SignatureValue®

This plan is a Health Maintenance Organization (HMO) and Managed Care Organization (MCO). Health services are accessed through contracting/participating network primary care physicians (PCPs) who know the Customer's medical history and individual needs. HMOs/MCOs offer minimal paperwork and low, predictable out-of-pocket costs. Customers pay a predetermined copayment or a percentage copayment each time they receive health care services.

Medicare Advantage products

Please reference the *Medicare Advantage Products* section of the UnitedHealthcare Guide for details on Medicare Advantage Products offered.

Verification of Customer eligibility

A Customer's eligibility and benefits must be verified each time the Customer receives services. We provide several ways to verify eligibility:

- Our provider website at PacifiCare.com
- Enhanced Voice Portal
- iExchange (available in CA, OK, OR, TX, WA; not available in AZ, CO, NV)
- Electronic eligibility lists (upon request)

Customer's benefit plan details

Additional details regarding a specific Customer's benefit plan, be it Commercial, Medicare Advantage, or any other benefit plan offered by PacifiCare, may be contained in the Customer's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, or may be addressed in procedures/protocols communicated by us. Such details may include, but are not limited to, the following:

- Selection of a PCP;
- Effective date of coverage;
- Changes in membership status while a Customer is in a hospital or skilled nursing facility (SNF);
- Customer transfer/disenrollment; or
- Removal of Customers from receiving services by a PCP.

For Customer-specific information, please contact:

- PacifiCare's Provider website at PacifiCare.com
- Enhanced Voice Portal
- iExchange (available in CA, OK, OR, TX, WA; not available in AZ, CO, NV)

Electronic Data Interchange (EDI) (does not apply in Nevada)

EDI is our preferred choice for conducting business transactions with contracting/participating physicians and healthcare industry partners. We accept EDI claims submission for all of our product lines, including PPO.

EDI tools

We offer an array of EDI tools designed to help you save time and money by automating several of your daily office administrative and reimbursement functions. Please refer to the PacifiCare-published Companion Guides for the required data elements.

1) Electronic eligibility inquiry/response

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. This EDI transaction is a powerful productivity tool that allows providers to instantly obtain Customers' eligibility and benefit information in "real-time," using a computer instead of the phone, prior to scheduling and confirming the Customer's appointment.

2) EDI claims/encounters

EDI claim is the preferred method of submission for PacifiCare physicians and health care professionals. You may submit all professional and institutional claims and/or encounters for our entire PacifiCare commercial HMO/MCO and Fee-For-Service product lines electronically.

3) Electronic claims status inquiry/response

This EDI transaction allows a provider to send and receive in "real-time" an electronic status of a previously submitted claim. Claims with missing or inaccurate information can be resubmitted, which greatly enhances the provider's receivables and cash flow cycle.

To determine the status of your submitted electronic claims, log on to PacifiCare.com. (You must first register online before receiving this information electronically.) Some software vendors and/or clearinghouses may also offer Electronic Claims Status and Inquiry transaction services. Or, you may call us at the phone number on the back of the Customer's health care ID card for more information.

4) Electronic Remittance Advice (ERA)

ERA allows a provider to obtain an electronic version of the PacifiCare Explanation of Payment (EOP). Depending on your system's capability, the data may be uploaded directly to the ledger of your practice computer system. ERA can potentially replace the tedious process of EOP reconciliation, posting and data entry.

Please refer to the PacifiCare-published Companion Guides for the data elements required for these transactions. Companion guides are available for viewing or download at PacifiCare.com.

We accept electronic transactions from multiple clearinghouses via Ingenix Health Information Networks (HIN). Please contact Ingenix HIN for verification if your current clearinghouse is connected to Ingenix or if you wish to establish a connectivity solution directly to Ingenix HIN. Transmissions must be submitted and received in a secure and protected method. Clearinghouses may or may not charge a one-time set up fee and/or a flat monthly rate to manage and support the transactions submitted and received.

With the exception of any required set-up and/or recurring monthly or annual fees, (if applicable), there may be a transaction fee for physicians and health care professionals to transmit EDI claims through Ingenix HIN.

Though we accept EDI claims sent directly to us, we prefer to conduct EDI business transactions primarily through

clearinghouses. Clearinghouses normally have established EDI connectivity to many payers. This arrangement benefits the physicians and health care professionals by allowing transmission of EDI transactions to multiple payers using a single connection.

For more information, please call (800) 203-7729 or contact us at edisupport@uhc.com.

Ingenix, HIN is available to assist you to begin submitting and receiving electronic transactions to and from PacifiCare. Please contact them at (800) 341-6141, option 3, for more information.

Begin submitting your claims and encounters electronically

- Before submitting your EDI claims to us, you must first refer to the back of the Customer's health care ID card to determine the appropriate PacifiCare product.
- Finally, refer to the EDI Payer ID Quick Reference Tool for the correct Payer ID number and the corresponding claim address of the PacifiCare product in your market.
- Claims previously submitted that were either denied or pended for additional information should not be resubmitted as electronically or as a new paper claim. Please contact us at the phone number on the back of the Customer's health care ID card for more information.

EDI Payer ID Quick Reference Tool

Market	Product type	EDI Payer ID
Commercial / PacifiCare SignatureValue (HMO/MCO)		
California, Oregon, Washington, Oklahoma, Texas	Commercial/HMO	87726
Colorado & Arizona	Commercial/HMO	95962
Nevada	Commercial/HMO	P.O. Box 95638 Las Vegas, NV 89193-5638 Call P5 Health Solutions (702) 318-2468
Medicare Advantage		
California , Oregon, Washington, Texas, Oklahoma, Colorado, Arizona	AARP MedicareComplete, SecureHorizons & Evercare	87726
Nevada	AARP MedicareComplete, SecureHorizons & Evercare	Las Vegas, NV 89193-5638 Call P5 Health Solutions (702) 318-2468
All Markets	SecureHorizons MedicareDirect	87726
Point of Service (POS) PacifiCare SignaturePOS (POS)		
California, Arizona, Colorado, Oregon, Washington, Nevada	POS	87726 95964 95962 87726, P.O. Box 98319 Las Vegas, NV 89193-8319, Call P5 Health Solutions (702) 318-2468
PacifiCare SignaureElite℠ PacifiCare SignatureIndependence® (Indemnity)		
California	Medicare Senior Supplemental (PPO)	95999
California, Nevada, Texas, Oklahoma, Arizona, Oregon, Washington	PPO/Indemnity	95999
Colorado	PPO/Indemnity	95999
Oklahoma & Texas	SignatureElite Plus	87726
PacifiCare Encounters		
All Markets (Except Nevada)	Online:	encountercollection@ingenix.com
For Additional PacifiCare EDI Information	Visit us:	PacifiCare.com
To Get Started with PacifiCare EDI or EDI Technical Support	Call: Write to:	(800) 203-7729 edisupport@uhc.com

Refer to the Customer's health care ID card for the appropriate PacifiCare product name that corresponds to the Payer ID listed above.

The Payer ID is an identification number that instructs the clearinghouse where to send your electronic claims/encounters. In some cases, the Payer ID listed above may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must validate with your clearinghouse for the appropriate PacifiCare Payer ID number or refer to your clearinghouse published Payer Lists.

Medical management

The purpose of the Medical Management Program is to determine if medical services are:

- Covered under the Customer's PacifiCare benefit plan;
- Medically necessary and appropriate; and
- Performed at both the appropriate place and level of care.

In evaluating medical appropriateness of services, PacifiCare uses Milliman Care Guidelines.

Compliance with the medical management program

Complying with the Medical Management Program includes, but is not limited to:

- Allowing PacifiCare staff to have on-site access to Customers and their families while the Customer is an inpatient;
- Allowing PacifiCare staff to participate in individual case conferences;
- Facilitating the availability and accessibility of key personnel for case reviews and discussions with PacifiCare's Medical Director or designee, upon request;
- Providing appropriate services in a timely manner.

Types of treatment

Medical emergencies/emergency medical conditions

Please check the Customer's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for how the plan defines emergency care. In general medical emergencies/emergency medical conditions are manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the Customer or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- "Active labor" – a labor at a time when either of the following would occur:
    - Inadequate time to effect safe transfer to another hospital prior to delivery;
    - Transfer may pose a threat to the health and safety of the Customer and/or unborn child.

The Customer should call 911 or its local equivalent, or should be directed to the nearest emergency room.

Prior authorization/notification is not required. However, notification of your emergency should be provided telephonically by calling us at (800) 799-5252 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

After hours and weekend emergency services should be provided as clinically appropriate the request should be entered into iExchange or faxed to PacifiCare at (800) 274-0569 on the next business day.

Urgently needed services

Please check the Customer's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for how the plan defines urgent care. In general, urgently needed services are services: (a) that are required without delay to prevent the serious deterioration of a Customer's health as a result of an unforeseen illness

or injury; and (b) for which it was not reasonable, given the circumstances, to obtain in accordance with the terms of the Customer's benefit plan. You must contact the Customer's PCP or hospitalist upon a Customer's arrival for services. These services should be requested telephonically by calling us at (800) 799-5252 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Routine

All other services are considered routine. To request preauthorization, the PCP must enter all the necessary information into iExchange, or complete and submit the appropriate Preauthorization Request Form. Routine requests will be responded to within the following timeframes if all pertinent clinical information is received:

Product	State	Timeframe
Medicare Advantage Urgent	All	72 Hours
Medicare Advantage Standard	All	14 Calendar Days
Commercial Urgent	OR, WA	2 Business Days
	CA, NV, OK, CO, AZ	72 Hours
	Texas	3 Calendar Days
Commercial Routine	NV	15 Calendar Days
	OR, WA	2 Business Days Exception - a delay of decision (DOD) letter
	CA	5 Business Days Exception - a delay of decision (DOD) letter
	OK, CO, AZ	15 Calendar Days
	TX	3 Calendar Days

Authorization status determination

Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may determine whether to delay, modify or deny services to a Customer for reasons of medical necessity.

Preauthorization

A list of services that require preauthorization is available at PacifiCare.com → Providers → Login → Library → Select State → Resource Center. Services that are rendered without the required preauthorization will be denied as provider liability. The Customer cannot be billed for such services.

- Most in-office PCP and specialty services do not require preauthorization.
- Contracting/participating network physicians and health care professionals should refer Customers to network providers. Referrals to non-network providers require preauthorization from us.
- Once the PCP refers a Customer to a network specialist, that specialist may then see the Customer as needed for the referring diagnosis. The specialist is not required to direct the Customer back to the PCP to order tests and/or treatment.
- If a specialist feels that a Customer needs other services related to the treatment of the referral diagnosis, the specialist may then refer the Customer, according to the PacifiCare Preauthorization List, to a contracting/participating network physician or ancillary provider.

PacifiCare or its agents shall conduct review throughout a Customer's course of treatment. Multiple authorizations may be required throughout such course of treatment as authorizations may be limited to specific services or time periods.

Referral process

If there are no network specialty or ancillary providers identified within the service area for a necessary service, the physician must submit a completed PacifiCare Referral/Treatment Authorization Form to PacifiCare/delegated Medical Group for approval. The Treatment Authorization Form can be found at PacifiCare.com → Providers → Login → Library → Select State → Forms.

Primary care services

Most PCP services do not require prior authorization. However, if prior authorization is required, the following guidelines apply:

1. The PCP is responsible for verifying eligibility and benefits prior to rendering services;
2. To request prior authorization, the PCP must enter the request into iExchange or complete and submit the appropriate Preauthorization Request Form (unless the services are required urgently or on an emergency basis). The completed Treatment Request Form must include the following information:
   - Customer's presenting complaint,
   - Physician's clinical findings on exam,
   - All diagnostic and lab results relevant to the request,
   - Conservative treatment that has been tried,
   - Applicable CPT and ICD-9-CM codes;
3. The PCP may also check the status of a treatment request through iExchange;
4. Upon approval, the treatment request will be given a tracking number that can be viewed through iExchange or will be faxed to the physician office via a return fax;
5. The tracking number should be noted on the claim when it is submitted for payment;
6. All authorizations expire 90 calendar days from the date of issuance.

Referrals for serious or complex medical conditions

The PCP should identify any PacifiCare Customers with serious or complex medical conditions and develop appropriate treatment plans for these Customers, in conjunction with case management. The treatment plan should include an authorization for referral to a specialist for an adequate number of visits to accommodate the treatment plan.

Specialty care (including gynecology) in an office-based setting

1. The specialist will receive via fax or an iExchange notice (approved as requested, approved as modified, delayed or denied) of the status of the authorization request for services requiring prior authorization. For those services that do not require prior authorization, the specialist office will receive a referral request directly from the PCP;
2. All specialist authorizations will expire 90 calendar days from the date of issuance;
3. Plain film radiography rendered by a designated PacifiCare contracting/participating provider, or in the specialist's office in support of an authorized visit, does not require prior authorization;
4. Routine lab services that are performed in the specialist's office, or are provided by a designated PacifiCare contracting/participating provider in support of an authorized visit, do not require prior authorization;
5. PacifiCare Customers may self-refer to a contracting/participating gynecologist for their annual routine gynecological exams. PacifiCare Customers in Colorado may self-refer to a participating gynecologist. The only exception to the OB/GYN direct access process is OB/GYN specialists whose practices primarily consist of subspecialty care such as Infertility or genetics. Such specialists can be accessed only by referral from the Customer's Primary Care Physician.
6. PacifiCare Medicare Advantage female Customers over age 40 may self-refer to a contracting/participating radiology provider for a screening mammogram. (NOTE: Mammograms may require authorization in California.)

Obstetrics

1. A Customer may self-refer to a contracting/participating obstetrician for routine obstetrical (OB) care. If the Customer is referred to a non-contracted specialist, the specialist must notify us through iExchange or by fax at the number designated on the top of the Prior Authorization Form to ensure accurate claims payment for ante and postpartum care.
2. Routine OB care includes office visits and 2 ultrasounds.
3. Plain film radiography that is performed by a PacifiCare Medicare Advantage contracting/participating provider or in the obstetrician's office in support of an authorized visit, do not require prior authorization.
4. Routine labs that are performed in the obstetrician's office, or are provided by a designated PacifiCare contracting/participating provider in support of an authorized visit, do not require prior authorization.
5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician's office that do not require prior authorization may be performed.

Specialty care in a hospital setting

All specialty care performed in a hospital setting requires prior authorization. This includes all surgical procedures, diagnostic testing, or therapeutic services performed in a facility setting and other facility-based services.

Second opinions (California commercial only)

We will authorize and provide a second opinion consultation by an appropriately qualified health care professional for Customers who meet specific criteria. A second opinion consists of one office visit for a consultation or evaluation only. Customers must return to their assigned PCPs for all follow-up care. A health care professional is defined as a PCP or specialist who is acting within the scope of practice and who possesses a clinical background, including training and expertise related to the Customer's particular illness, disease or condition.

The PCP may request a second opinion on behalf of the Customer in any of the following situations:

1. The Customer questions the reasonableness or necessity of a recommended surgical procedure;
2. The Customer questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function, or threatens substantial impairment, including, but not limited to, a serious chronic condition;
3. The clinical indications are not clear or are complex and confusing;
4. A diagnosis is in doubt due to conflicting test results;
5. The treating health professional is unable to diagnose the condition;
6. The Customer's medical condition is not responding to the prescribed treatment plan within an appropriate period of time, and the Customer is requesting a second opinion regarding the diagnosis or continuance of the treatment; or
7. The Customer has attempted to follow the treatment plan or has consulted with the initial provider and has serious concerns about the diagnosis or treatment plan.

Post-stabilization care

Customers are covered for post-stabilization services following emergency services. Post-stabilization services are medically necessary, but non-emergent, services needed to ensure the Customer remains stabilized from the time the treating hospital requests authorization from Medical Management until one of the following occurs:

1. The Customer is discharged;
2. A plan physician arrives and assumes responsibility for the Customer's care; or
3. The treating physician and PacifiCare agree to another arrangement.

We are responsible for the cost of post-stabilization services that are:

- Pre-approved by us; and
- Medically necessary.

Post-stabilization care will be deemed approved if we do not respond within 1 hour to the request for post-stabilization care or we cannot be contacted for pre-approval.

Extension of prior authorization services

If a Customer requires services beyond the initial consult and follow-up visits in any of the situations where we require prior authorization, the specialist must request an extension of authorization through iExchange or by fax:

1. Beyond the approved visits;
2. Beyond the allotted timeframe of the approval (typically 90 calendar days);
3. If a Customer requires procedures, and/or diagnostic or therapeutic testing, requiring prior authorization.

The extension must be authorized before care is rendered to the Customer. The request for extension of services must include the following information:

- Customer's presenting complaint;
- Physician's clinical findings on exam;
- All diagnostic and laboratory results relevant to the request;
- Conservative treatment that has been tried;
- Applicable CPT and ICD-9-CM codes.

We will amend the existing authorization to reflect the extension and will mail or fax it back to the physician and/or make the information available on iExchange. There is no need to contact the Customer's PCP.

Inpatient authorization procedures

Preauthorization is required for all non-urgent/non-emergent inpatient services provided in an acute care hospital, rehabilitation facility and a skilled nursing facility (SNF). Hospitals, rehabilitation facilities and SNFs are required to notify us of all admissions, changes in inpatient status and discharge dates daily.

Additionally, authorization is required as follows:

- Certain urgent/emergent admissions require prior authorization; please verify benefits prior to requesting authorization.
- Elective/scheduled medical admissions require prior authorization.
- For admissions or transfers after-hours or on weekends, the Customer should be admitted to the appropriate facility at the appropriate level of care. Authorization can then be obtained on the next business day.
- Authorization is not required for a consultation with a contracted in-network provider during an inpatient stay. However, consultation with a non-contracted, non-network provider requires prior authorization.
- Transfers/admissions to SNFs; a Customer can be admitted directly from the emergency room or home to a SNF.
- A referral to a non-network facility requires preauthorization from us. However, in the case of a life-threatening emergency, a non-contracted hospital may be used without prior authorization. After initial emergency treatment and/or post-stabilization, we may request that a Customer be transferred to a network hospital when medically appropriate. If a PCP directs a Customer to a non-network hospital without preauthorization, the PCP may be held responsible.

Required authorizations can be obtained through iExchange or by completing and faxing the Treatment Authorization Form to the appropriate fax telephone number located at the top of the Treatment Authorization Form. If the PacifiCare

Prior Authorization Nurse is unable to authorize the admission or procedure, the request will be referred to our Medical Director. If the Customer's recovery requires an extension of days beyond those authorized, the Concurrent Review Nurse will contact the hospital for clinical indications for extension. Please note that issuance of a tracking number does not constitute authorization for admission.

Failure to comply with this notification requirement will result in non-payment to the hospital or SNF and their providers for all charges until notification is received and services have been authorized.

Hospital notification

Independent from Prior Authorization, notification by the facility is required for inpatient admissions on the day of admission for urgent/emergent, scheduled/elective, medical surgical, OOA, hospice, and obstetrical services.

Inpatient census reports

The following reports must be faxed daily to our Clinical Information department:

- Census report for all our Customers;
- Discharge report;
- Face sheets to report outpatient surgeries and SNF admissions;
- Inpatient Admission Fax Sheet to report "no PacifiCare admissions" for that day;

The census report or face sheets must include the following information:

- Primary Medical Group/IPA
- Admit date
- Customer name (first and last)
- Date of birth
- Bed type/accommodation status/level of care (LOC)
- Length of stay (LOS)
- Admitting physician
- Admitting diagnosis (ICD-9-CM)
- Procedure/surgery (CPT Code) or reason for admission
- Attending physician
- Facility
- City/State
- Policy number/Customer ID number
- Other insurance
- Authorization number (if available)

The discharge report must include Customer demographic information, discharge date and disposition.

Coordination of care

Facilities are required to assist in the coordination of a Customer's care by:

- Working with the Customer's PCP;
- Notifying the PCP of any admissions; and
- Providing the PCP with discharge summaries.

Concurrent review

We will conduct concurrent review on all admissions from the day of admission through discharge. Concurrent review is performed telephonically, as well as on-site at designated facilities, by clinical staff. We have established procedures for on-site concurrent review which include: (a) guidelines for identification of our staff at the facility; (b) processes for scheduling on-site reviews in advance; and (c) requiring our staff to follow facility rules. If the clinical reviewer determines that the Customer may be treated at a lower level of care or in an alternative treatment setting, the case will be discussed with the hospital case manager and the admitting physician. If a discrepancy occurs, our Medical Director or designee will discuss the case with the admitting physician.

Variance days

If inpatient care coordination and provision of diagnostic services lack medical necessity or are not provided in a timely manner contributing to delays in care, variance days will be assigned and reimbursement adjusted accordingly. Our concurrent review staff will attempt to minimize variance days by working with the attending physicians and hospital staff. If a variance is noted in the patient's acute care process, a discussion occurs with the hospital's medical management /case management representative and our concurrent review staff. The variance is documented in our utilization records and submitted to the Concurrent Review Manager for approval. If approved, the variance is entered into our database as a denial of reimbursement for the variance time period. A letter stating the variance type and time period will be mailed to the facility. The facility may appeal the variances in writing. Our Medical Director will review the appeal and render a decision to overturn or uphold the decision.

Medical observation status

We will authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a Customer's medical condition and determine the need for actual admission, or to stabilize a Customer's condition (typically, 23-48 hours). Typical cases, when observation status is used, include ruled-out diagnoses and medical conditions that respond quickly to care. Customers under observation status may later convert to an inpatient admission if medically necessary.

Emergency and/or direct urgent admissions

If a hospital does not receive authorization from us within: 1 hour of the initial call requesting authorization (for Medicare Advantage or PacifiCare commercial Customers), the emergent and/or urgent services prompting the admission are assumed to be authorized and should be documented as such to us until we direct or arrange care for the Customer. Once we become involved with managing or directing the Customer's care, all services provided must be authorized by us.

Skilled Nursing Facilities (SNFs)

Before transfer/admit to a SNF, PacifiCare or its designee must approve the Customer's treatment plan. The Customer's network physician must perform the initial physical exam and complete a written report within 48 hours of a Customer's admission to the SNF. We will perform an initial review and subsequent reviews as we deem necessary. Federal and State regulations require that Customers at skilled level facilities be seen by a physician at least once every 30 calendar days.

Discharge planning

Discharge planning is the coordination of a Customer's anticipated continuing care needs following discharge. The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Assessing and documenting the Customer's needs upon admission, including the Customer's functional status and anticipated discharge disposition, if other than home;
- Developing the discharge plan, including evaluation of the Customer's financial and social service needs and potential need for post-hospital services, such as home health, DME, and/or placement in a SNF or custodial care facility;
- Obtaining authorizations for necessary post-discharge plan;

- Organizing, communicating and executing the discharge plan;
- Evaluating the effectiveness of the discharge plan;
- Making timely referral to population-based disease management and case management programs, as indicated;

For after-hours or weekend discharges requiring home health and/or DME, the care should be arranged and authorization can be obtained, as indicated above, on the next business day.

Retrospective review/medical claim review

Medical claim review, also known as medical cost review, medical bill review and/or retrospective review, is the examination of the medical documentation and/or billing detail after a service has been provided. Medical claim review is performed to provide a fair and consistent means to retrospectively review medical claims to ensure medical necessity criteria are met, confirm appropriate level of care and length of stay, correct payer source and identify appropriate potential unbundling and/or duplicate billing occurrences.

The review includes an examination of all appropriate claims and/or medical records against accepted billing practices as defined by entities such as Medicare AMA, CPT coding and Milliman Care Guidelines depending on the type of claims submitted.

Claims that meet any of the following criteria are reviewed before the claim is paid:

- High dollar claims;
- Claims without required authorization;
- Claims for unlisted procedures;
- Trauma claims;
- Implants that are not identified on PacifiCare's Implant Guidelines used by PacifiCare's Claim Department;
- Claim check or modifier edits based on PacifiCare's claim payment software;
- Foreign claims;
- Claims with LOS or LOC mismatch.

To ensure timely review and payment determinations, the physician, health care professional, facility or ancillary provider must respond to requests for all appropriate medical records within 5-7 calendar days from receipt of the request.

If prior or concurrent authorization for a covered service provided to a Customer has been obtained, PacifiCare or its agents will not retrospectively deny payment for such authorized covered services unless the claim and/or medical record for such services does not support the specific services and/or level of care authorized by PacifiCare or its agents or does not match the specific service that was authorized. We may review specific claims based on pre-established retrospective criteria to ensure acceptable billing practices are applied.

For hospital providers, we may reduce the payable dollars if line item charges have been incorrectly unbundled from room and board charges.

Minimum content of written or electronic notification

Written or electronic notices to deny, delay in delivery, or modify a request for authorization for health care services will, at a minimum, include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the plan provisions to support the decision;
- The reason the service is being denied, delayed in delivery, modified, or partially approved, including:
    - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision;

- Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
- Clinical reasons for decisions regarding medical necessity; and
- Contractual rationale for benefit denials.

- Notification that the Customer can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Notification that the Customer's physician can request a peer to peer review;
- Alternative treatment options offered, if applicable;
- Description of any additional material or information necessary for the Customer to "perfect" the request, and why that information is necessary;
- Description of grievance rights and an explanation of the appeals and grievances processes, including:
  - Information regarding the Customer's right to appoint a representative to file an appeal on the Customer's behalf,
  - The Customer's right to submit written comments, documents or other additional relevant information,
  - Information notifying the Customer and their treating provider of the right to an expedited appeal for time-sensitive situations (not applicable to retrospective review);
  - Information regarding the Customer's right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
  - Information that the Customer may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable (Commercial products only);
  - For the treating provider, the name and direct telephone number of the health care professional responsible for the decision.

Notice of denials and Medicare appeal rights (hospitals only)

Hospitals are required to issue to a written notice of non-coverage to a Customer when the Customer disagrees with a hospital discharge if:

- PacifiCare or its agents have authorized coverage of the Customer's inpatient hospital admission; or
- The admission constitutes an emergency or urgently needed care.

Behavioral health management

PacifiCare delegates behavioral health care services to PacifiCare Behavioral Health of California (PBHC), PacifiCare Behavioral Health, Inc. (PBHI) and United Behavioral Health (UBH). UBH provides PCPs with assistance on behavioral health issues for all three entities through the Physician Consultation Service. Information on behavioral health care services is available at: unitedbehavioralhealth.com. UBH can be contacted directly via email at ubhonline.com; or by calling (800) 292-2922, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Pacific Time.

Pharmacy formulary

Customer benefit plans may or may not include pharmacy coverage. Our Commercial formulary includes most generic drugs and a broad selection of brand name drugs. Prescription drugs/medications listed on the formulary are considered a covered benefit. However, select formulary medications may require prior authorization in order to be covered.

In some instances, a Customer's pharmacy plan may not include coverage for non-formulary prescriptions/medications. In these instances, the costs are the Customer's financial responsibility, unless the prescribing physician requests prior authorization review for the non-formulary medications and the Customer meets our criteria for coverage.

To access the formulary and changes to the formulary, go to PacifiCare.com → Providers → Library → Click on the

desired state → Pharmacy → Click on the desired formulary. You will then be able to search by drug name or therapeutic class. Any restriction or limitation will also be noted along with formulary alternatives, when applicable. The formulary is updated twice a year, in January and July. Physician requests for formulary review of medications or preauthorization guidelines are welcome. Prior authorization guideline change request forms and formulary change request forms can be obtained by going to PrescriptionSolutions.com → HealthCare Professionals Home Page → Healthcare Provider Tools → Forms and Documents.

Prior authorization/exception process

We have a prior authorization process to provide for coverage of select formulary and non-formulary/non-covered medications. We delegate prior authorization services to Prescription Solutions®. Prescription Solutions staff will adhere to plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards in reviewing each case.

Request for prior authorization of non-formulary medications

The request for prior authorization of a non-formulary drug may only be made by the physician or a designated employee or individual under the direction and control of the physician, who is located in the physician's office or other site where the Customer is receiving medical services. The prior authorization functions may not be delegated to a third-party who is not located at the physician's office or other site where the Customer is receiving medical services. However, clinical pharmacists who work in a medical management capacity within a medical group, and who are directly employed by or contracted with that medical group may also make requests.

You can request an authorization by:

- **Telephone:** Toll-free: (800) 711-4555
- **Written request:** Fax: (800) 527-0531 for oral medications and (800) 853-3844 for injectable/specialty medications. You can obtain a Prior Authorization Medications Request Form at PacifiCare.com after login or through PrescriptionSolutions.com → Prior Authorizations.
- **Online:** PrescriptionSolutions.com → Healthcare Professionals → Prior Authorizations → Prior Authorization Request Form. Enter the patient and physician information, select "add medication" and complete the required fields. Prescription Solutions will contact the physician to validate the prior authorization request. This form can only be utilized for oral medication requests.

The prior authorization request must include specific information related to the Customer's medical condition and course of treatment, as requested by Prescription Solutions. Prescription Solutions will not process the request until all necessary information has been submitted. Prescription Solutions will communicate with the physician or designated employee or other individual under the direction and control of the physician regarding whether the non-formulary drug will be covered. Once all requested necessary information has been received, Prescription Solutions will make its determination within the applicable time frame. No decision will be made on requests that are incomplete or require additional information.

Non-formulary medications and/or other medications that require prior authorization may be authorized in accordance with benefit design, provided the Customer's benefit restrictions (applied to both the requested agent(s)/therapeutic class, and the prior authorization process) are not exceeded, and when 1 or more of the following criteria is met:

- The requested non-formulary medication has limited efficacy and relatively high incidence of side effects, but indication for specific disease management meets criteria outlined in the National Pharmacy & Therapeutics Committee (NPTC) Guidelines;
- Documented failure of a therapeutic trial of a formulary agent(s);
- The Formulary alternative(s) is/are contraindicated for treatment;
- The Customer is currently maintained and stabilized on a non-formulary medication previously approved by the

plan that is not excluded from coverage;

- The Customer experienced allergic reaction(s) to the formulary alternative (e.g., rash, urticaria, drug fever, anaphylactic type, or established adverse effects as published in the package insert of respective product relating to the pharmacological properties of the medications, formulations or differences in absorption, distribution, or elimination of the medications);
- The Customer meets established medical necessity criteria per clinical guidelines and/or standards, and
- No other formulary agent is appropriate to meet the Customer's condition.

The prescriber provides compelling medical evidence supporting the use of the requested non-formulary medication over the formulary agent where the requested therapeutic class is necessary for medical management.

The following information is required to evaluate each case prior to issuance of an authorization:

- Customer's name
- Customer's ID number
- Customer's date of birth
- Customer's gender
- Prescriber's name
- Prescriber's specialty
- Prescriber's address
- Prescriber's phone/fax number
- Name and dosage strength of the requested medication
- Directions for use
- Diagnosis
- Date Customer was started on the non-formulary medication
- Name of specific drugs tried and failed
- Documentation of patient chart notes in accordance with the specifications outlined in the NPTC Guidelines or, where appropriate, as the community standard of practice
- Any other compelling medical information that would support the use of the non-formulary medication over a formulary alternative

A written communication of case resolution is faxed to the provider for each case serviced. If prior authorization is approved, the medication will be covered for the applicable cost sharing. If prior authorization is denied, the Customer is responsible for paying the cost of the prescription.

Denial determinations require a letter to be sent to both Customer and prescriber stating the reason why the non-formulary medication is being denied and outlining the process for filing standard and expedited appeals.

Additional information (applies only to Medicare Advantage)

For Medicare Advantage Customers, Prescriptions Solutions' Prior Authorization staff will follow the coverage determination timelines as established by the Centers for Medicare and Medicaid (CMS). Standard coverage determinations must be completed within 72 hours. Expedited coverage determinations must be completed within 24 hours. Prescription Solutions will communicate with the physician or designated employee, or other individual under the direction and control of the physician, and the Customer regarding whether or not the non-formulary drug will be covered or the cost-sharing exception is approved.

For Medicare Advantage Customers, under certain circumstances and on an individual basis, Customers or physicians may

request a reduction in the copayment or coinsurance amount for a drug on the Formulary. A Tier 3 Non-preferred drug may be requested for a Tier 2 copayment/coinsurance instead of the higher Tier 3 copayment/coinsurance amount. A Tier 2 generic drug may be requested for a Tier 1 copayment/coinsurance instead of the higher Tier 2 copayment/coinsurance amount. Prescription Solutions will not grant an exception to the copayment/coinsurance amount for or Tier 4 drugs.

Criteria for cost share reduction are: 1) whether the Customer has failed or has contraindications or intolerance to all equivalent formulary drugs in lower preferred tiers (i.e., Tier 1 and Tier 2); and 2) whether the drug is FDA approved for the condition being treated, or its use is supported by a citation in one of the following compendia:

- AHFS (American Hospital Formulary Service) Drug Information; or
- USPDI (United States Pharmacopeia-Drug Information); (or its successor publication)
- DRUGDEX Information System from Micromedex.

Non-formulary/non-covered products that are approved through the exceptions process are not eligible for further cost-sharing reductions to Tier 1 or Tier 2 levels.

Authorizing and dispensing injectable/infusion medications

Customers may use the Prescription Solutions Specialty Pharmacy or a participating network retail pharmacy to obtain covered self-injectable and injectable/infusion medications. A list of participating retail pharmacies is available at prescriptionsolutions.com. All medications are subject to the Customer's benefit plan and delegation of medical/physician groups.

The physician must submit the following information to request a covered injectable and/or self-injectable medication for a Customer:

- Complete Prior Authorization Form (the requesting physician's signature is required to allow the vendor to accept the document as a legal prescription);
- Recent history and physical
- Copies of any pertinent laboratory results
- Copies of any reports by consultant providers

Submit requests to the Prescription Solutions Specialty Pharmacy at (800) 711-4555, or fax requests directly to (800) 853-3844.

Prescription Solutions will verify the Customer's eligibility, notify the physician of the determination, and if appropriate, contact the physician's office to coordinate delivery of the medication(s). In the case of approved self-injectables, the vendor will contact the Customer to coordinate delivery of the medication(s).

For those self administered drugs that may be covered by Medicare Part D, please refer or download a copy of the formulary online at PacifiCare.com, AARPMedicareComplete.com, or SecureHorizons.com.

Claims processing

Claims adjudication

PacifiCare utilizes industry claims adjudication and/or clinical practices, state and federal guidelines, and/or PacifiCare policies, procedures and data to determine appropriate criteria for payment of claims. To find out more about this information, please contact your Network Account Manager or Physician Advocate or Hospital Advocate, as applicable, or visit our website at PacifiCare.com.

Complete claims requirements

We follow the UnitedHealthcare complete claims requirements, as found in the beginning of this Guide.

National Provider Identification (NPI)

United and its affiliates are able to accept the NPI on all HIPAA transactions, including the HIPAA 837 professional and

institutional (paper and electronic) claim submissions. A valid NPI is required on all covered claims (paper and electronic) in addition to the tax identification number (TIN). For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy.

PacifiCare will accept NPIs submitted through any of the following methods:

- **website:** PacifiCare.com → Provider → Electronic Data Interchange (EDI)/NPI. Here you will find complete details regarding NPI.
- **Telephone:** (877) 842-3210 through the United Voice Portal, select the "Health Care Professional Services" prompt. State "Demographic changes" and your call will be directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.

Level of care documentation and claims payment

PacifiCare processes claims according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, PacifiCare will pay only the authorized level of care and the Customer shall not be billed for any charges relating to the higher level of care. If the billed level of care is at a lower level than authorized, PacifiCare will pay the provider based on the lower level of care, which was determined by provider to be the appropriate level of care for the Customer.

Customer financial responsibility

Reference the PacifiCare and SecureHorizons Copayment Guideline Grids at PacifiCare.com → Login → Library → Guidelines & Interpretation Manuals for more information about interpretation of copayments.

Services provided to ineligible Customers

In the event that PacifiCare provides eligibility confirmation indicating that a Customer is eligible at the time the health care services are provided and it is later determined that the patient was not in fact eligible, PacifiCare will not be responsible for payment of services provided to the Customer, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the Customer (to the extent permitted by law) or from any other source of payment.

Authorization guarantee procedure (Commercial only)

Authorization Guarantee provides for reimbursement to the Provider for covered services provided to an Customer for which (1) an authorization has been provided, (2) who is determined to have been ineligible with PacifiCare on the date the authorized services were rendered and (3) where the Customer's lack of eligibility is only determined after authorized services have been rendered. The Authorization Guarantee does not apply to self-insured or Medicare Advantage benefit plans.

Provider's responsibility to monitor eligibility

PacifiCare makes available current Customer eligibility information through the Enhanced Voice Portal, PacifiCare Provider Portal, and PacifiCare Customer Service Center ("800#"). The Provider is responsible for checking Customer eligibility within 2 business days prior to the date of service. Provider shall be eligible for reimbursement under the Authorization Guarantee program described herein for authorized services provided that Provider has checked and confirmed eligibility within 2 business days prior to the date of service.

Authorization guarantee and reimbursement procedure

Currently, PacifiCare's systems automatically deny claims for services provided to patients who are not eligible regardless of prior authorization. PacifiCare reviews all these fee for service claims denials based on lack of eligibility to determine whether services are eligible for reimbursement. PacifiCare will overturn denials that are payable under the Authorization

Guarantee program without any action by provider. Additionally, the provider must submit the following information to the PacifiCare Provider Dispute Resolution Team (at: PPO Provider Disputes, PO BOX 6098 Cypress, CA 90630) for Authorization Guarantee reimbursement consideration:

- Coversheet* *
- Copy of the itemized bill for services rendered;
- Proof of eligibility verification within 2 business days prior to the date of service;
- A copy of the authorization for the services rendered;
- A record of any payment received from any other responsible payor, and amount due based on Provider's contract with PacifiCare, less any payment received from any other responsible payor.

For services covered by the Authorization Guarantee program, PacifiCare will reimburse Provider in the amount that would have been due to Provider had the same services been provided to an eligible Customer.

Note: If, before or after PacifiCare makes a payment under the Authorization Guarantee Procedure, the Provider receives payment for the same services from another source, the Provider shall refund the amount received from the other source to PacifiCare, not to exceed the amount paid by PacifiCare, within 45 working days.

Claims status follow up

If, after submitting a claim within timely filing guidelines, you have not received an Explanation of Payment (EOP) within the timeframes in accordance with state and federal law, the provider may follow-up on the status of a claim using one of the following methods:

- Online at PacifiCare.com → Provider → Login → Check Eligibility. The website provides real-time data and is the quickest method for retrieving claim status information or call the provider line at the toll-free number found on the back of the Customer's health care ID card.
- You may also submit an Electronic Transaction (HIPAA 276/277). Please contact your EDI clearing house for additional information.
- Enhanced Voice Portal now provides access to claim status information by calling the toll-free number found on the back of the Customer's health care ID card, and simply following the prompt instructions over the telephone. This system provides a fax of the claim status detail information that is available.

Claims submission requirements

Claims shall be submitted to PacifiCare on industry standard forms (CMS-1500's, UB-04's) and forwarded to the address listed on the eligible PacifiCare Medicare Advantage Customer's ID card. Refer to the EDI section of this Guide for more information about electronic claims submission and other Electronic Data Interchange (EDI) transactions available with PacifiCare. If your claim is the financial responsibility of a PacifiCare delegated entity (e.g.PMG, MSO, Hospital you should bill that entity directly for reimbursement.

Claims submission requirements for reinsurance claims for hospital providers

If contracted covered services fall under the reinsurance provisions set forth in your agreement with us, you shall abide by the terms of the agreement in ensuring that:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
- Only those inpatient services specifically identified under the terms of the reinsurance provision(s) may be used to calculate the stipulated threshold rate;

* Authorization Guarantee Coversheet can be obtained from Pacificare.com
For CA/CO/OK/OR/TX/WA only: Pacificare.com → Provider → After Login → Library → Provider Policy & Procedures Manual → Policies and Procedures (2010)
For AZ/NV only: Pacificare.com → Provider → After Login → Library → Guidelines & Interpretation Manuals → Policies and Procedures (2010)

- Applicable eligible Customer copayments, coinsurance, and/or deductible amounts are deducted from the reinsurance threshold computation;
- The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and submitted claims;
- The reinsurance is applied to the specific, authorized acute care confinement;
- Submitted in accordance with the stipulated timeframe, if any, as stipulated in the agreement.

In addition, when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in accordance with the terms stipulated in the Agreement and/or this guide, you shall:

- Indicate if a claim meets reinsurance criteria;
- Make medical records available upon request for all related services identified under the reinsurance provisions (i.e., ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria, PacifiCare shall continue to process the claim at the stipulated appropriate LOC per diem rate. In order to compute specific reinsurance calculations and to properly review reinsurance claims for covered services, an itemized bill is required.

Interim bills

We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete charges to the interim payments based on the final bill.

The process outlined below will increase efficiencies for both us and the Hospital/SNF business offices:

- 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 114 Interim – Last Claim: Review admit to discharge and discharge and apply appropriate contract rates, including per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final payable amount.

Reciprocity agreements

You shall cooperate with PacifiCare's contracting/participating providers and other PacifiCare-affiliated entities and agree to provide services to Customers enrolled in benefit plans and programs of UnitedHealthcare affiliates and to assure reciprocity of providing health care services.

Without limiting the foregoing, if any Customer who is enrolled in a benefit plan or program of any PacifiCare affiliate, receives services or treatment from you and your sub-contracted providers (if applicable), you and your sub-contracted providers (if applicable), agrees to bill the PacifiCare affiliate at billed charges and to accept the compensation provided pursuant to your agreement, less applicable copayments and/or deductibles, as payment in full for such services or treatment.

You shall comply with the procedures established by PacifiCare or the PacifiCare affiliate and this agreement for reimbursement of such services or treatment.

Overpayments

If you identify a claim for which you were overpaid by us, or if we inform you of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. If refund or dispute is not made within 45 calendar days of PacifiCare's request, PacifiCare shall recoup the amount of overpayment through other means, which may include future claim payments, to the extent permitted by your agreement with us and applicable law.

All refunds of overpayments in response to overpayment refund requests received from us, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter.

Please include appropriate documentation that outlines the overpayment, including Customer's name, health care ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from us. If the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund.

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician or other contracting/participating health care professional. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim reconsideration, or as provided by applicable law. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you must submit the dispute, in writing, to the recovery agent requesting the overpayment. The agent's name and address is located on the recovery request letter.

If you dispute the refund request, the recovery of claims overpayment will not occur until after you have exhausted our appeals process. (See *Claim Appeals* section of this supplement.)

Medicare opt-out providers

PacifiCare abides by, and requires its providers to abide by, Medicare's physician/practitioner opt-out policy. Physicians/practitioners who opt-out of Medicare (this may include physicians/practitioners not participating in Medicare) are not allowed to bill Medicare or its Medicare Advantage plans for 2 years from the date of official opt-out. PacifiCare and its delegated entities will not contract with, or pay claims to, providers who have opted-out of Medicare for Medicare Advantage membership.

Exception: In an emergency or urgent care situation, a physician/practitioner who opts-out of Medicare may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a non-participating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with the physician/practitioner.

End-stage renal disease

If a Customer has (or develops) end stage renal disease (ESRD) while covered under an employer's group plan, the Customer must use the benefits of the plan for the first 30 months after becoming eligible for Medicare, based on ESRD. After the 30 months elapse, Medicare is then the primary Payor. However, if the employer group plan coverage were secondary to Medicare when the Customer developed ESRD Medicare would be the primary Payor.

Medicaid (applies only to Medicare Advantage)

Qualified Medicare Beneficiaries (QMB) are held harmless for Medicare cost-sharing under applicable CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copayments included under Medicare Advantage Plans.

Physicians and health care professionals will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage Customer who is eligible for both Medicare and Medicaid, or said Customer's representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g. copays, deductibles, coinsurance) when the State is responsible for paying such amounts. Physicians and health care professionals will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate State source for such cost sharing amount.

Time limits for filing claims

All physicians and health care professionals are required to submit to PacifiCare clean claims for reimbursement no later than the time specified in the provider's participation agreement or the timeframe specified in the state guidelines, whichever is greater.

If a provider fails to submit clean claims to PacifiCare within the foregoing timeframes, PacifiCare reserves the right to deny payment for such claim(s). Claim(s) which are denied for untimely filing cannot be billed to a Customer.

PacifiCare has established internal claims processing procedures to ensure timely claims payment to its physicians and health care professionals. PacifiCare is committed to paying claims for which it is financially responsible within the timeframes required by state and federal law.

For purposes of determining the date of PacifiCare's or it's delegate receipt of a claim, the date of receipt shall be deemed to be the working day when a claim, by physical or electronic means, is first delivered to PacifiCare's specified claims payment office, post office box, designated claims processor or to PacifiCare's capitated provider for that claim. The following date stamps may be used to determine date of receipt.

- PacifiCare Claims Department date stamp
- Primary Payor claim payment/denial date as shown on the EOP
- Delegated Provider date stamp
- TPA date stamp
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender

Note: Date stamps from other health plans or insurance companies are not valid received dates for timely filing determination.

Provider appeals

Claims research and resolution (applies to commercial in Arizona, Colorado, Nevada, Oklahoma & Texas)

The Claims Research & Resolution (CR&R) process applies:

- If you do not agree with the payment decision after the initial processing of the claim; and
- Regardless of whether the payer was PacifiCare, the delegated Medical Group/IPA or other delegated payer, or the capitated hospital/provider. You are responsible for submitting your claim(s) to the appropriate entity that holds financial responsibility to process each claim.

We will research the issue to identify the payer who holds financial risk for the services and will abide by federal and state legislation on appropriate timelines for resolution. We will work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

Claim reconsideration requests (does not apply in California)

You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). You should submit your request to PacifiCare in writing by using the Claims Rework Request form (available at PacifiCare.com → Providers → Login → Library → Select State → Forms. All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines.

Please refer to the chart titled PacifiCare Provider Rework or Dispute Process Reference Table at the end of this section for the address to which your request should be sent.

Submission of bulk claim inquiries

The Claims Project Management (CPM) Team handles bulk claim inquiries. You should contact the CPM team at the address below to initiate a bulk claim inquiry:

PacifiCare bulk claims rework reference table		
Provider's state	**Contact information**	**Notes**
Arizona	PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078	Submit requests for 20 or more claims.
California	Claims Research Projects P.O. Box 30968 CA120-0360 Salt Lake City, UT 84130-0968	Submit requests for 19 or more claims.
Colorado	PacifiCare Claims Department Attn: Colorado Resolution Team P.O. Box 52064. Phoenix, AZ 85072-2064	Submit requests for 20 or more claims.
Nevada	*For SecureHorizons and Commercial HMO claims*: PacifiCare of Nevada Claims Research Projects P.O. Box 95638 Las Vegas, NV 89193-5638 *For Commercial POS claims:* PacifiCare of Nevada Claims Research Projects P.O. Box 98319 Las Vegas, NV 89193	The Nevada delegated payer handles bulk claim inquiries received from physicians and health care professionals of service. The provider of service should submit the bulk claims with a cover sheet indicating "Appeal" or "Review" to the Claims Research Department at the designated address to initiate a bulk claim inquiry. Submit requests for 10 or more claims.
Oklahoma	Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967	Submit requests for 20 or more claims.
Oregon	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 10 or more claims.
Texas	Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975	Submit requests for 20 or more claims.
Washington	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 10 or more claims.

PacifiCare's response

We will respond to issues as quickly as possible.

- **Reworks/disputes requiring medical determination:** Individuals with clinical training/background who were not previously involved in the initial decision will review all clinical rework/dispute requests. A letter will be sent to the provider outlining the outcome of the determination and the basis for the decision.
- **Reworks/disputes requiring claim process determination:** Individuals not previously involved in the initial processing of the claim will review rework/dispute request.
- **Response details:** If claim requires an additional payment, the EOP will serve as notification of the outcome on the review. If the original claim status is upheld, the provider will be sent a letter outlining the details of the review.
- **Applies to California only:** If claim requires an additional payment, the EOP, itself, is insufficient to serve as notification of the outcome of the review. A letter will be sent to the provider with the determination. In addition, payment must be sent within 5 calendar days of such determination based on the date on the determination letter.

We will respond to the provider within the applicable time limits set forth by Federal and State agencies. After the applicable time limit has passed, the provider may contact Provider Relations at (877) 847-2862 to obtain a status.

Provider Dispute Resolution (PDR) process (applies to commercial in California, Colorado, Oregon and Washington)

A provider dispute is a dispute of a claim for which a determination has previously been issued by us. You must submit a provider dispute in writing and accompanied by additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless other filing guidelines contained in your participation agreement or State law dictate otherwise. This timeframe applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of provider disputes, in accordance with State and Federal regulations. We will not discriminate, retaliate against or charge you for submitting a provider dispute. The PDR process is not a substitution for arbitration and will not be deemed as arbitration.

What to submit

As the provider of service, you should submit the dispute with the following information:

- Customer's name;
- Customer's ID number;
- Claim number;
- Specific item in dispute;
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved;
- Submitting provider's contract information.

Note: Physicians and health care professionals who do not submit the appropriate supporting documentation when requesting review of a previously processed claim will not have the dispute reviewed.

For California physicians and health care professionals: A Provider Dispute Resolution form can be obtained online at PacifiCare.com → Library → Select "Provider Disputes". The dispute resolution form is not required; however, the minimum requirements outlined in AB1455 must be met.

Where to submit

State-specific addresses and other pertinent information regarding the PDR process may be found in the PacifiCare Provider Rework or Dispute Process Reference Table at the end of this section.

Accountability for review of a provider dispute

The entity which initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, PacifiCare, the delegated medical group/IPA/payer or the capitated hospital/provider.

Excluded from the PDR process

The following are examples of issues that are excluded from the PDR process:

- Dates of service prior to January 1, 2004.
- Instances in which a Customer has filed an appeal and you have filed a dispute regarding the same issue. In these cases, the Customer's appeal will take precedence. You can submit a Provider Dispute after the Customer appeal decision is made. If you are appealing on behalf of the Customer, the appeal will be processed as a Customer appeal.
- An Independent Medical Review initiated by a Customer through the Customer Appeal Process.
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply "good cause" for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer's claim resolution mechanism.

- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/provider and does not involve an issue of medical necessity or medical management.

PacifiCare provider rework or dispute process reference table		
Provider's state	**Contact information**	**Notes**
Arizona	PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078	• First Review: Request for reconsideration of a claim is considered a Grievance. Physicians and health care professionals are required to notify PacifiCare in writing of any request for reconsideration within 1 year from the date the claim was processed. • Second Review: Request for reconsideration of a Grievance determination is also considered a Grievance. Physicians and health care professionals are required to notify PacifiCare in writing of any second level Grievance within 1 year from the date the first level Grievance resolution was communicated to the provider.
California	PacifiCare Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	• We will acknowledge receipt of the dispute within 15 business days of receipt of the dispute for disputes submitted by paper and within 2 business days of receipt of the disputes submitted electronically. We will issue a written determination to the provider within 45 business days. Also, we will return the provider dispute if additional information is required within 45 business days.
Colorado	PacifiCare Claims Department Attn: Colorado Resolution Team 4601 E. Hilton Ave. Phoenix, AZ 85034	• Upon receipt of a dispute, we will: • Send the provider a written acknowledgement of receipt of the dispute within 30 calendar days of the receipt of the dispute; • Conduct a thorough review of the provider's dispute and all supporting documentation; • Supply the provider with a written determination, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; • Process payment, if necessary, within 5 business days of the written determination; • Return the dispute to the provider of service within 30 calendar days if additional information is required; • If additional information is required, we will hold the dispute request for 30 additional calendar days.
Nevada	**For commercial HMO or SecureHorizons claims:** PacifiCare of Nevada P.O. Box 95638 Las Vegas, NV 89193-5638 **For commercial POS claims:** PacifiCare of Nevada P.O. Box 98319 Las Vegas, NV 89193	• All Nevada commercial and SecureHorizons and Evercare HMO claims are processed by a delegated payer. Therefore, the provider appeals are reviewed primarily by the delegated payer.
Oklahoma	PacifiCare, SecureHorizons and Evercare Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	
Oregon	PacifiCare and SecureHorizons Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	
Texas	PacifiCare Claims Department P. O. Box 400046 San Antonio, TX 78229	
Washington	PacifiCare and SecureHorizons Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	• We will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. • We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. • In the case of billing disputes, we will render a decision within 60 calendar days of the complaint.

Access & availability to medical & behavioral health services

We monitor Customers' access to medical and behavioral healthcare to ensure that we have an adequate provider network to meet the Customer's healthcare needs. We utilize Customer satisfaction surveys and Customer complaints to assess performance against standards.

We have established the following standards for access to care:

Type of Care	Guideline
Regular or routine	14 calendar days *Exceptions:* Arizona for PCP within15 days and for specialists within 60 days of Customer request or sooner if medically necessary; California Customers are offered appointments for non-urgent PCP within 10 business days of request, for non-urgent Specialist within 15 business days of request; Texas within 3 weeks for medical conditions
Preventive care	4 weeks *Exceptions:* Arizona within 60 days of Customer request, Texas within 2 months for child and within 3 months for adult. Medicare Advantage within 30 days
Non-urgent, but in need of attention (applies to Medicare Advantage only)	Within 1 week
Urgent exam (PCP or Specialist)	Same day (24 hours) *Exceptions:* Arizona requires access to care 7 days a week, California Customers are offered appointments within 48 hours when no prior authorization required, within 96 hours when prior authorization required
Emergent exam	Immediately (exception: only if open 24 hours a day/7 days a week).
PCP after-hours – on call coverage	24 hours per day, 7 days per week*
Office wait time	Less than 15 minutes from the time of the appointment until the Customer is with the physician in the exam room. Exceptions: California Customers office wait time is less than 30 minutes
Referral process	Notification to the Customer should be completed in a timely manner, not to exceed 5 business days of a request for non-urgent care, or 72 hours of a request for urgent care.
Non-urgent ancillary (diagnostic)	15 business days
Behavioral health care for a non-life-threatening emergency	6 hours
Behavioral health urgent care	24 hours
Behavioral health routine office visit	10 business days

* A physician's office after-hours line should provide a Customer access within 30 minutes to someone who can direct the Customer in determining/securing necessary care. The after-hours line may be monitored by an answering service that pages or contacts the on-call physician, or an answering machine with clear instructions and a second number to call to reach a physician or another person to page the physician. Regardless of the method, the after-hours communication must instruct the Customer to call 911 or go to the nearest emergency room if the Customer is experiencing an emergency.

1. Customers must have access to all physicians and support staff who work for the physician and must not be limited to particular physicians. We recognize that some substitution between physicians who work out of the same office/building may occur due to urgent/emergent situations.
2. Customers must have access to appointments during all normal office hours and will not be limited to appointments on certain days or during certain hours.
3. Customers must have access to time slots that are the same as all other patients seen by the physician who are not PacifiCare Customers.
4. The physician must work cooperatively with our Medical Management department toward:

- Managing inpatient and outpatient utilization;
- Customer care and Customer satisfaction;
- As an "authorization representative" of the health plan, physicians are responsible to notify the Customer about the prior authorization determination, unless State regulation requires otherwise.

5. The physician will use best efforts to refer Customers to PacifiCare network providers.
6. The physician must utilize only PacifiCare network laboratory and radiology providers, unless specifically authorized.
7. All provider and physician offices must provide after hours care instructions on their telephone message or answering service for appropriate emergency instructions. The specific guidelines are:
   Emergency instructions are provided to ever after-hours caller, whether a line is answered live or by recording. Callers with an emergency are expected to be told to:
   - Hang up and dial 911, or
   - Go to the nearest emergency room.

Timely access to non-emergency health care services (applies only in California, effective January 17, 2011)

- The timeliness standards require licensed health care providers to offer Customers appointments that meet the California timeframes. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Customer.
- Triage or screening services by telephone must be provided by licensed staff, 24 hours per day, 7 days per week. Under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an Customer or determine when an Customer needs to be seen by a licensed medical professional.
- PacifiCare of California Commercial HMO/POS Customers have access to free telephonic triage and screening services 24 hours a day, 7 days a week through OptumHealth's Nurseline at (866) 747-4325.

California Language Assistance Program (applies only to Commercial in California)

California law establishes standards and requirements for health plans to provide commercial HMO Customers who have limited English proficiency with accessibility to translated written materials and oral interpretation services, free of charge, to assist such Customers in obtaining covered services.

Customer complaints & grievances

We acknowledge that Customer disputes may arise with the health plan or its contracting/participating providers, especially related to coverage issues. PacifiCare respects the rights of its Customers to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All Customers receive instructions on how to file a complaint/grievance with PacifiCare in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.

Provider profile

The Provider Profile represents a comprehensive report card that helps medical groups manage their respective performance in over 70 areas of clinical quality, utilization management, service quality and administrative efficiency. Quarterly performance is profiled with information obtained through the claims and encounter data reporting system. Medical groups are scored on indicators that compare their performance to past trended results, as well as to network averages and national benchmarks. (Only available for California.)

Copies of the California QUALITY INDEX® Profiles are available on the PacifiCare.com's provider and Customer web portals.

QUALITY INDEX Profile of Medical Groups

The QUALITY INDEX® Profile of Medical Groups is our award-winning public report on medical group performance. The Index takes approximately 40 of the most important and reliable measures from the Provider Profile and reports the relative performance achieved by the medical groups in the contracted network. Those groups that perform in the top 90th percentile on any of the measures exemplifying clinical and service quality and accountability earn public recognition for their "Best Practice" status. In addition to highlighting the "Best Practices" in each category, performance in all measures in an Overall Clinical, Overall Service and Overall Affordability score is summarized. The QUALITY INDEX Profile provides consumers with an effective tool to help make more informed healthcare decisions. It also fosters a healthy competition among provider groups – competition that has improved healthcare quality throughout the contracting/ participating network.

When available, standardized HEDIS and CAHPS measures are incorporated into the QUALITY INDEX Profile. A subset of these measures, including most of the Integrated Healthcare Association pay-for-performance measures, have been used for both the Quality Incentive Program and for the Value Network design of a narrow HMO network based on lower costs and higher quality. (Not available in all states.)

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UnitedHealthcareOnline.com

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Filed-Closed	01/21/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Filed-Closed	01/21/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Filed-Closed	01/21/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Filed-Closed	01/21/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Filed-Closed	01/21/2011
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number:	*UHLC-126996988*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*47765*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2011 AR Admin Guide*		
Project Name/Number:	*/*		

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter	Filed-Closed	01/21/2011

Comments:

The Redline comparison is to large to be attached. I will forward it to you via email as soon as this filing is assigned.

Attachment:

AR Admin Guide Cover letter 1.21.11.pdf

UnitedHealthcare®
A UnitedHealth Group Company

January 21, 2011

Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas Inc.

NAIC No. 95446 United Healthcare of Arkansas, Inc. ®
Group Health Form 100-6088 12/10

Dear Ms. Minor:

On behalf of UnitedHealthcare of Arkansas Inc., I am submitting the enclosed UHC Provider Administrative Guide for your Department's review and approval. Enclosed within this filing is a copy of the current version and a redlined version of the form which outlines the recent changes to the form.

This submission has been submitted electronically via SERFF and UnitedHealthcare of Arkansas, Inc. recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 240.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Sincerely,

Ebony N. Terry
Regulatory Compliance Analyst